

104TH CONGRESS
1ST SESSION

H. R. 2485

To amend title XVIII of the Social Security Act to preserve and reform
the medicare program.

IN THE HOUSE OF REPRESENTATIVES

OCTOBER 17, 1995

Mr. ARCHER (for himself, Mr. BLILEY, Mr. BILIRAKIS, Mr. THOMAS, Mr. HYDE, Mr. GREENWOOD, Mr. HASTERT, Mrs. JOHNSON of Connecticut, and Mr. MCCREY) introduced the following bill; which was referred to the Committee on Ways and Means, and in addition to the Committees on Commerce, the Judiciary, and Rules, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to preserve
and reform the medicare program.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. PURPOSE.**

4 The purpose of this Act is to reform the medicare
5 program, in order to preserve and protect the financial
6 stability of the program.

TITLE XV—MEDICARE

SEC. 15000. SHORT TITLE OF TITLE; AMENDMENTS AND REFERENCES TO OBRA; TABLE OF CONTENTS OF TITLE.

(a) **SHORT TITLE.**—This title may be cited as the “Medicare Preservation Act of 1995”.

(b) **AMENDMENTS TO SOCIAL SECURITY ACT.**—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) **REFERENCES TO OBRA.**—In this title, the terms “OBRA–1986”, “OBRA–1987”, “OBRA–1989”, “OBRA–1990”, and “OBRA–1993” refer to the Omnibus Budget Reconciliation Act of 1986 (Public Law 99–509), the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203), the Omnibus Budget Reconciliation Act of 1989 (Public Law 101–239), the Omnibus Budget Reconciliation Act of 1990 (Public Law 101–508), and the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66), respectively.

(d) **TABLE OF CONTENTS OF TITLE.**—The table of contents of this title is as follows:

Sec. 15000. Short title of title; amendments and references to OBRA; table of contents of title.

Subtitle A—MedicarePlus Program

PART 1—INCREASING CHOICE UNDER THE MEDICARE PROGRAM

- Sec. 15001. Increasing choice under medicare.
- Sec. 15002. MedicarePlus program.

“PART C—PROVISIONS RELATING TO MEDICAREPLUS

- “Sec. 1851. Requirements for MedicarePlus organizations; high deductible/medisave products.
- “Sec. 1852. Requirements relating to benefits, provision of services, enrollment, and premiums.
- “Sec. 1853. Patient protection standards.
- “Sec. 1854. Provider-sponsored organizations.
- “Sec. 1855. Payments to MedicarePlus organizations.
- “Sec. 1856. Establishment of standards for MedicarePlus organizations and products.
- “Sec. 1857. MedicarePlus certification.
- “Sec. 1858. Contracts with MedicarePlus organizations.”
- Sec. 15003. Duplication and coordination of medicare-related products.
- Sec. 15004. Transitional rules for current medicare HMO program.

PART 2—SPECIAL RULES FOR MEDICAREPLUS MEDICAL SAVINGS ACCOUNTS

- Sec. 15011. MedicarePlus MSA’s.
- Sec. 15012. Certain rebates excluded from gross income.

PART 3—SPECIAL ANTITRUST RULE FOR PROVIDER SERVICE NETWORKS

- Sec. 15021. Application of antitrust rule of reason to provider service networks.

PART 4—COMMISSIONS

- Sec. 15031. Medicare Payment Review Commission.
- Sec. 15032. Commission on the Effect of the Baby Boom Generation on the Medicare Program.
- Sec. 15033. Change in appointment of Administrator of HCFA.

PART 5—TREATMENT OF HOSPITALS WHICH PARTICIPATE IN PROVIDER-SPONSORED ORGANIZATIONS

- Sec. 15041. Treatment of hospitals which participate in provider-sponsored organizations.

Subtitle B—Preventing Fraud and Abuse

PART 1—GENERAL PROVISIONS

- Sec. 15101. Increasing awareness of fraud and abuse.
- Sec. 15102. Beneficiary incentive programs.
- Sec. 15103. Intermediate sanctions for medicare health maintenance organizations.
- Sec. 15104. Voluntary disclosure program.
- Sec. 15105. Revisions to current sanctions.
- Sec. 15106. Direct spending for anti-fraud activities under medicare.
- Sec. 15107. Permitting carriers to carry out prior authorization for certain items of durable medical equipment.
- Sec. 15108. National Health Care Anti-Fraud Task Force.

- Sec. 15109. Study of adequacy of private quality assurance programs.
- Sec. 15110. Penalty for false certification for home health services.
- Sec. 15111. Pilot projects.

PART 2—CRIMINAL LAW PROVISIONS

- Sec. 15121. Offenses involving fraud, false statement, theft, or embezzlement.

Subtitle C—Regulatory Relief

PART 1—PHYSICIAN OWNERSHIP REFERRAL REFORM

- Sec. 15201. Repeal of prohibitions based on compensation arrangements.
- Sec. 15202. Revision of designated health services subject to prohibition.
- Sec. 15203. Delay in implementation until promulgation of regulations.
- Sec. 15204. Exceptions to prohibition.
- Sec. 15205. Repeal of reporting requirements.
- Sec. 15206. Preemption of State law.
- Sec. 15207. Effective date.

PART 2—OTHER MEDICARE REGULATORY RELIEF

- Sec. 15211. Repeal of Medicare and Medicaid Coverage Data Bank.
- Sec. 15212. Clarification of level of intent required for imposition of sanctions.
- Sec. 15213. Additional exception to anti-kickback penalties for managed care arrangements.
- Sec. 15214. Solicitation and publication of modifications to existing safe harbors and new safe harbors.
- Sec. 15215. Issuance of advisory opinions under title XI.
- Sec. 15216. Prior notice of changes in billing and claims processing requirements for physicians' services.

PART 3—PROMOTING PHYSICIAN SELF-POLICING

- Sec. 15221. Exemption from antitrust laws for certain activities of medical self-regulatory entities.

Subtitle D—Medical Liability Reform

PART 1—GENERAL PROVISIONS

- Sec. 15301. Federal reform of health care liability actions.
- Sec. 15302. Definitions.
- Sec. 15303. Effective date.

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- Sec. 15311. Statute of limitations.
- Sec. 15312. Calculation and payment of damages.
- Sec. 15313. Alternative dispute resolution.

Subtitle E—Teaching Hospitals and Graduate Medical Education

PART 1—TEACHING HOSPITAL AND GRADUATE MEDICAL EDUCATION TRUST FUND

- Sec. 15401. Establishment of Fund; payments to teaching hospitals.

“TITLE XXII—TEACHING HOSPITAL AND GRADUATE MEDICAL
EDUCATION TRUST FUND

“PART A—ESTABLISHMENT OF FUND

“Sec. 2201. Establishment of Fund.

“PART B—PAYMENTS TO TEACHING HOSPITALS

“Subpart 1—Requirement of Payments

“Sec. 2211. Formula payments to teaching hospitals.

“Subpart 2—Amount Relating to Indirect Costs of Graduate Medical
Education

“Sec. 2221. Determination of amount relating to indirect costs.

“Sec. 2222. Indirect costs; special rules regarding determination of hospital-specific percentage.

“Sec. 2223. Indirect costs; alternative payments regarding teaching hospitals in certain States.

“Subpart 3—Amount Relating to Direct Costs of Graduate Medical
Education

“Sec. 2231. Determination of amount relating to direct costs.

“Sec. 2232. Direct costs; special rules regarding determination of hospital-specific percentage.

“Sec. 2233. Direct costs; authority for payments to consortia of providers.

“Sec. 2234. Direct costs; alternative payments regarding teaching hospitals in certain States.

“Subpart 4—General Provisions

“Sec. 2241. Adjustments in payment amounts.”

PART 2—AMENDMENTS TO MEDICARE PROGRAM

Sec. 15411. Transfers to Teaching Hospital and Graduate Medical Education Trust Fund.

Sec. 15412. Modification in payment policies regarding graduate medical education.

PART 3—REFORM OF FEDERAL POLICIES REGARDING TEACHING HOSPITALS
AND GRADUATE MEDICAL EDUCATION

Sec. 15421. Establishment of advisory panel for recommending policies.

“PART C—OTHER MATTERS

“Sec. 2251. Advisory Panel on Reform in Financing of Teaching Hospitals and Graduate Medical Education.”

Subtitle F—Provisions Relating to Medicare Part A

PART 1—HOSPITALS

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- Sec. 15502. Reductions in disproportionate share payment adjustments.
- Sec. 15503. Payments for capital-related costs for inpatient hospital services.
- Sec. 15504. Reduction in adjustment for indirect medical education.
- Sec. 15505. Treatment of PPS-exempt hospitals.
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- Sec. 15507. Permanent extension of hemophilia pass-through.
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SUBPART B—PROVISIONS RELATING TO RURAL HOSPITALS

- Sec. 15511. Sole community hospitals.
- Sec. 15512. Clarification of treatment of EAC and RPC hospitals.
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PART 2—PAYMENTS TO SKILLED NURSING FACILITIES

- Sec. 15521. Payments for routine service costs.
- Sec. 15522. Incentives for cost effective management of covered non-routine services.
- Sec. 15523. Payments for routine service costs.
- Sec. 15524. Reductions in payment for capital-related costs.
- Sec. 15525. Treatment of items and services paid for under part B.
- Sec. 15526. Certification of facilities meeting revised nursing home reform standards.
- Sec. 15527. Medical review process.
- Sec. 15528. Report by Medicare Payment Review Commission.
- Sec. 15529. Effective date.

PART 3—CLARIFICATION OF CREDITS TO PART A TRUST FUND

- Sec. 15531. Clarification of amount of taxes credited to Federal Hospital Insurance Trust Fund.

Subtitle G—Provisions Relating to Medicare Part B

PART 1—PAYMENT REFORMS

- Sec. 15601. Payments for physicians' services.
- Sec. 15602. Elimination of formula-driven overpayments for certain outpatient hospital services.
- Sec. 15603. Payments for durable medical equipment.
- Sec. 15604. Reduction in updates to payment amounts for clinical diagnostic laboratory tests.
- Sec. 15605. Extension of reductions in payments for costs of hospital outpatient services.
- Sec. 15606. Freeze in payments for ambulatory surgical center services.
- Sec. 15607. Rural emergency access care hospitals.
- Sec. 15608. Ensuring payment for physician and nurse for jointly furnished anesthesia services.
- Sec. 15609. Statewide fee schedule area for physicians' services.
- Sec. 15609A. Establishment of fee schedule for ambulance services.
- Sec. 15609B. Standards for physical therapy services furnished by physicians.

PART 2—PART B PREMIUM

- Sec. 15611. Extension of part B premium.
- Sec. 15612. Income-related reduction in medicare subsidy.

PART 3—ADMINISTRATION AND BILLING OF LABORATORY SERVICES

- Sec. 15621. Administrative simplification for laboratory services.
- Sec. 15622. Restrictions on direct billing for laboratory services.

PART 4—QUALITY STANDARDS FOR DURABLE MEDICAL EQUIPMENT

- Sec. 15631. Recommendations for quality standards for durable medicare equipment.

Subtitle H—Provisions Relating to Medicare Parts A and B

PART 1—PAYMENT FOR HOME HEALTH SERVICES

- Sec. 15701. Payment for home health services.
- Sec. 15702. Maintaining savings resulting from temporary freeze on payment increases for home health services.
- Sec. 15703. Extension of waiver of presumption of lack of knowledge of exclusion from coverage for home health agencies.
- Sec. 15704. Report on recommendations for payments and certification for home health services of Christian Science providers.
- Sec. 15705. Extension of period of home health agency certification.

PART 2—MEDICARE SECONDARY PAYER IMPROVEMENTS

- Sec. 15711. Extension and expansion of existing requirements.
- Sec. 15712. Improvements in recovery of payments.
- Sec. 15713. Prohibiting retroactive application of policy regarding ESRD beneficiaries enrolled in primary plans.

PART 3—FAILSAFE

- Sec. 15721. Failsafe budget mechanism.

PART 4—ADMINISTRATIVE SIMPLIFICATION

- Sec. 15731. Standards for medicare information transactions and data elements.

PART 5—OTHER PROVISIONS RELATING TO PARTS A AND B

- Sec. 15741. Clarification of medicare coverage of items and services associated with certain medical devices approved for investigational use.
- Sec. 15742. Additional exclusion from coverage.
- Sec. 15743. Competitive bidding for certain items and services.
- Sec. 15744. Disclosure of criminal convictions relating to provision of home health services.
- Sec. 15745. Requiring renal dialysis facilities to make services available on a 24-hour basis.

Subtitle I—Clinical Laboratories

- Sec. 15801. Exemption of physician office laboratories.

**Subtitle J—Lock-Box Provisions for Medicare Part B Savings
from Growth Reductions**

Sec. 15901. Establishment of Medicare Growth Reduction Trust Fund for Part B savings.

1 Subtitle A—MedicarePlus Program

2 PART 1—INCREASING CHOICE UNDER THE

3 MEDICARE PROGRAM

4 SEC. 15001. INCREASING CHOICE UNDER MEDICARE.

5 (a) IN GENERAL.—Title XVIII is amended by insert-
6 ing after section 1804 the following new section:

7 “PROVIDING FOR CHOICE OF COVERAGE

8 “SEC. 1805. (a) CHOICE OF COVERAGE.—

9 “(1) IN GENERAL.—Subject to the provisions of
10 this section, every individual who is entitled to bene-
11 fits under part A and enrolled under part B shall
12 elect to receive benefits under this title through one
13 of the following:

14 “(A) THROUGH FEE-FOR-SERVICE SYS-
15 TEM.—Through the provisions of parts A and
16 B.

17 “(B) THROUGH A MEDICAREPLUS PROD-
18 UCT.—Through a MedicarePlus product (as de-
19 fined in paragraph (2)), which may be—

20 “(i) a high deductible/medisave prod-
21 uct (and a contribution into a
22 MedicarePlus medical savings account
23 (MSA)),

1 “(ii) a product offered by a provider-
2 sponsored organization,

3 “(iii) a product offered by an organi-
4 zation that is a union, Taft-Hartley plan,
5 or association, or

6 “(iv) a product providing for benefits
7 on a fee-for-service or other basis.

8 “(2) MEDICAREPLUS PRODUCT DEFINED.—For
9 purposes this section and part C, the term
10 ‘MedicarePlus product’ means health benefits cov-
11 erage offered under a policy, contract, or plan by a
12 MedicarePlus organization (as defined in section
13 1851(a)) pursuant to and in accordance with a con-
14 tract under section 1858.

15 “(3) TERMINOLOGY RELATING TO OPTIONS.—
16 For purposes of this section and part C—

17 “(A) NON-MEDICAREPLUS OPTION.—An
18 individual who has made the election described
19 in paragraph (1)(A) is considered to have elect-
20 ed the ‘Non-MedicarePlus option’.

21 “(B) MEDICAREPLUS OPTION.—An indi-
22 vidual who has made the election described in
23 paragraph (1)(B) to obtain coverage through a
24 MedicarePlus product is considered to have

1 elected the ‘MedicarePlus option’ for that prod-
2 uct.

3 “(b) SPECIAL RULES.—

4 “(1) RESIDENCE REQUIREMENT.—Except as
5 the Secretary may otherwise provide, an individual is
6 eligible to elect a MedicarePlus product offered by a
7 MedicarePlus organization only if the organization
8 in relation to the product serves the geographic area
9 in which the individual resides.

10 “(2) AFFILIATION REQUIREMENTS FOR CER-
11 TAIN PRODUCTS.—

12 “(A) IN GENERAL.—Subject to subpara-
13 graph (B), an individual is eligible to elect a
14 MedicarePlus product offered by a limited en-
15 rollment MedicarePlus organization (as defined
16 in section 1852(c)(4)(E)) only if—

17 “(i) the individual is eligible under
18 section 1852(c)(4) to make such election,
19 and

20 “(ii) in the case of a MedicarePlus or-
21 ganization that is a union sponsor or a
22 Taft-Hartley sponsor (as defined in section
23 1852(c)(4)), the individual elected under
24 this section a MedicarePlus product offered
25 by the sponsor during the first enrollment

1 period in which the individual was eligible
2 to make such election with respect to such
3 sponsor.

4 “(B) NO REELECTION AFTER
5 DISENROLLMENT FOR CERTAIN PRODUCTS.—
6 An individual is not eligible to elect a
7 MedicarePlus product offered by a
8 MedicarePlus organization that is a union spon-
9 sor or a Taft-Hartley sponsor if the individual
10 previously had elected a MedicarePlus product
11 offered by the organization and had subse-
12 quently discontinued to elect such a product of-
13 fered by the organization.

14 “(3) SPECIAL RULE FOR CERTAIN ANNU-
15 ITANTS.—An individual is not eligible to elect a high
16 deductible/medisave product if the individual is enti-
17 tled to benefits under chapter 89 of title 5, United
18 States Code, as an annuitant or spouse of an annu-
19 itant.

20 “(c) PROCESS FOR EXERCISING CHOICE.—

21 “(1) IN GENERAL.—The Secretary shall estab-
22 lish a process through which elections described in
23 subsection (a) are made and changed, including the
24 form and manner in which such elections are made
25 and changed. Such elections shall be made or

1 changed only during coverage election periods speci-
 2 fied under subsection (e) and shall become effective
 3 as provided in subsection (f).

4 “(2) EXPEDITED IMPLEMENTATION.—The Sec-
 5 retary shall establish the process of electing coverage
 6 under this section during the transition period (as
 7 defined in subsection (e)(1)(B)) in such an expedited
 8 manner as will permit such an election for
 9 MedicarePlus products in an area as soon as such
 10 products become available in that area.

11 “(3) COORDINATION THROUGH MEDICAREPLUS
 12 ORGANIZATIONS.—

13 “(A) ENROLLMENT.—Such process shall
 14 permit an individual who wishes to elect a
 15 MedicarePlus product offered by a
 16 MedicarePlus organization to make such elec-
 17 tion through the filing of an appropriate elec-
 18 tion form with the organization.

19 “(B) DISENROLLMENT.—Such process
 20 shall permit an individual, who has elected a
 21 MedicarePlus product offered by a
 22 MedicarePlus organization and who wishes to
 23 terminate such election, to terminate such elec-
 24 tion through the filing of an appropriate elec-
 25 tion form with the organization.

1 “(4) DEFAULT.—

2 “(A) INITIAL ELECTION.—

3 “(i) IN GENERAL.—Subject to clause
4 (ii), an individual who fails to make an
5 election during an initial election period
6 under subsection (e)(1) is deemed to have
7 chosen the Non-MedicarePlus option.

8 “(ii) SEAMLESS CONTINUATION OF
9 COVERAGE.—The Secretary shall establish
10 procedures under which individuals who
11 are enrolled with a MedicarePlus organiza-
12 tion at the time of the initial election pe-
13 riod and who fail to elect to receive cov-
14 erage other than through the organization
15 are deemed to have elected an appropriate
16 MedicarePlus product offered by the orga-
17 nization.

18 “(B) CONTINUING PERIODS.—An individ-
19 ual who has made (or deemed to have made) an
20 election under this section is considered to have
21 continued to make such election until such time
22 as—

23 “(i) the individual changes the elec-
24 tion under this section, or

1 “(ii) a MedicarePlus product is dis-
 2 continued, if the individual had elected
 3 such product at the time of the discontinu-
 4 ation.

5 “(5) AGREEMENTS WITH COMMISSIONER OF SO-
 6 CIAL SECURITY TO PROMOTE EFFICIENT ADMINIS-
 7 TRATION.—In order to promote the efficient admin-
 8 istration of this section and the MedicarePlus pro-
 9 gram under part C, the Secretary may enter into an
 10 agreement with the Commissioner of Social Security
 11 under which the Commissioner performs administra-
 12 tive responsibilities relating to enrollment and
 13 disenrollment in MedicarePlus products under this
 14 section.

15 “(d) PROVISION OF BENEFICIARY INFORMATION TO
 16 PROMOTE INFORMED CHOICE.—

17 “(1) IN GENERAL.—The Secretary shall provide
 18 for activities under this subsection to disseminate
 19 broadly information to medicare beneficiaries (and
 20 prospective medicare beneficiaries) on the coverage
 21 options provided under this section in order to pro-
 22 mote an active, informed selection among such op-
 23 tions. Such information shall be made available on
 24 such a timely basis (such as 6 months before the
 25 date an individual would first attain eligibility for

1 medicare on the basis of age) as to permit individ-
 2 uals to elect the MedicarePlus option during the ini-
 3 tial election period described in subsection (e)(1).

4 “(2) USE OF NONFEDERAL ENTITIES.—The
 5 Secretary shall, to the maximum extent feasible,
 6 enter into contracts with appropriate non-Federal
 7 entities to carry out activities under this subsection.

8 “(3) SPECIFIC ACTIVITIES.—In carrying out
 9 this subsection, the Secretary shall provide for at
 10 least the following activities in all areas in which
 11 MedicarePlus products are offered:

12 “(A) INFORMATION BOOKLET.—

13 “(i) IN GENERAL.—The Secretary
 14 shall publish an information booklet and
 15 disseminate the booklet to all individuals
 16 eligible to elect the MedicarePlus option
 17 under this section during coverage election
 18 periods.

19 “(ii) INFORMATION INCLUDED.—The
 20 booklet shall include information presented
 21 in plain English and in a standardized for-
 22 mat regarding—

23 “(I) the benefits (including cost-
 24 sharing) and premiums for the var-

1 ious MedicarePlus products in the
2 areas involved;

3 “(II) the quality of such prod-
4 ucts, including consumer satisfaction
5 information; and

6 “(III) rights and responsibilities
7 of medicare beneficiaries under such
8 products.

9 “(iii) PERIODIC UPDATING.—The
10 booklet shall be updated on a regular basis
11 (not less often than once every 12 months)
12 to reflect changes in the availability of
13 MedicarePlus products and the benefits
14 and premiums for such products.

15 “(B) TOLL-FREE NUMBER.—The Secretary
16 shall maintain a toll-free number for inquiries
17 regarding MedicarePlus options and the oper-
18 ation of part C.

19 “(C) GENERAL INFORMATION IN MEDI-
20 CARE HANDBOOK.—The Secretary shall include
21 information about the MedicarePlus option pro-
22 vided under this section in the annual notice of
23 medicare benefits under section 1804.

24 “(e) COVERAGE ELECTION PERIODS.—

1 “(1) INITIAL CHOICE UPON ELIGIBILITY TO
2 MAKE ELECTION.—

3 “(A) IN GENERAL.—In the case of an indi-
4 vidual who first becomes entitled to benefits
5 under part A and enrolled under part B after
6 the beginning of the transition period (as de-
7 fined in subparagraph (B)), the individual shall
8 make the election under this section during a
9 period (of a duration and beginning at a time
10 specified by the Secretary) at the first time the
11 individual both is entitled to benefits under part
12 A and enrolled under part B. Such period shall
13 be specified in a manner so that, in the case of
14 an individual who elects a MedicarePlus prod-
15 uct during the period, coverage under the prod-
16 uct becomes effective as of the first date on
17 which the individual may receive such coverage.

18 “(B) TRANSITION PERIOD DEFINED.—In
19 this subsection, the term ‘transition period’
20 means, with respect to an individual in an area,
21 the period beginning on the first day of the first
22 month in which a MedicarePlus product is first
23 made available to individuals in the area and
24 ending with the month preceding the beginning

1 of the first annual, coordinated election period
2 under paragraph (3).

3 “(2) DURING TRANSITION PERIOD.—Subject to
4 paragraph (6)—

5 “(A) CONTINUOUS OPEN ENROLLMENT
6 INTO A MEDICARE-PLUS OPTION.—During the
7 transition period, an individual who is eligible
8 to make an election under this section and who
9 has elected the non-MedicarePlus option may
10 change such election to a MedicarePlus option
11 at any time.

12 “(B) OPEN DISENROLLMENT BEFORE END
13 OF TRANSITION PERIOD.—

14 “(i) IN GENERAL.—During the transi-
15 tion period, an individual who has elected
16 a MedicarePlus option for a MedicarePlus
17 product may change such election to an-
18 other MedicarePlus product or to the non-
19 MedicarePlus option.

20 “(ii) SPECIAL RULE.—During the
21 transition period, an individual who has
22 elected a high deductible/medisave product
23 may not change such election to a
24 MedicarePlus product that is not a high
25 deductible/medisave product unless the in-

1 dividual has had such election in effect for
2 12 months.

3 “(3) ANNUAL, COORDINATED ELECTION PE-
4 RIOD.—

5 “(A) IN GENERAL.—Subject to paragraph
6 (5), each individual who is eligible to make an
7 election under this section may change such
8 election during annual, coordinated election pe-
9 riods.

10 “(B) ANNUAL, COORDINATED ELECTION
11 PERIOD.—For purposes of this section, the
12 term ‘annual, coordinated election period’
13 means, with respect to a calendar year (begin-
14 ning with 1998), the month of October before
15 such year.

16 “(C) MEDICAREPLUS HEALTH FAIR DUR-
17 ING OCTOBER, 1996.—In the month of October,
18 1996, the Secretary shall provide for a nation-
19 ally coordinated educational and publicity cam-
20 paign to inform individuals, who are eligible to
21 elect MedicarePlus products, about such prod-
22 ucts and the election process provided under
23 this section (including the annual, coordinated
24 election periods that occur in subsequent years).

1 “(4) SPECIAL 90-DAY DISENROLLMENT OP-
2 TION.—

3 “(A) IN GENERAL.—In the case of the first
4 time an individual elects a MedicarePlus option
5 (other than a high deductible/medisave product)
6 under this section, the individual may dis-
7 continue such election through the filing of an
8 appropriate notice during the 90-day period be-
9 ginning on the first day on which the individ-
10 ual’s coverage under the MedicarePlus product
11 under such option becomes effective.

12 “(B) EFFECT OF DISCONTINUATION OF
13 ELECTION.—An individual who discontinues an
14 election under this paragraph shall be deemed
15 at the time of such discontinuation to have
16 elected the Non-MedicarePlus option.

17 “(5) SPECIAL ELECTION PERIODS.—An individ-
18 ual may discontinue an election of a MedicarePlus
19 product offered by a MedicarePlus organization
20 other than during an annual, coordinated election
21 period and make a new election under this section
22 if—

23 “(A) the organization’s or product’s certifi-
24 cation under part C has been terminated or the

1 organization has terminated or otherwise dis-
2 continued providing the product;

3 “(B) in the case of an individual who has
4 elected a MedicarePlus product offered by a
5 MedicarePlus organization, the individual is no
6 longer eligible to elect the product because of a
7 change in the individual’s place of residence or
8 other change in circumstances (specified by the
9 Secretary, but not including termination of
10 membership in a qualified association in the
11 case of a product offered by a qualified associa-
12 tion or termination of the individual’s enroll-
13 ment on the basis described in clause (i) or (ii)
14 section 1852(c)(3)(B));

15 “(C) the individual demonstrates (in ac-
16 cordance with guidelines established by the Sec-
17 retary) that—

18 “(i) the organization offering the
19 product substantially violated a material
20 provision of the organization’s contract
21 under part C in relation to the individual
22 and the product; or

23 “(ii) the organization (or an agent or
24 other entity acting on the organization’s
25 behalf) materially misrepresented the prod-

1 uct’s provisions in marketing the product
2 to the individual; or

3 “(D) the individual meets such other con-
4 ditions as the Secretary may provide.

5 “(6) SPECIAL RULE FOR HIGH DEDUCTIBLE/
6 MEDISAVE PRODUCTS.—Notwithstanding the pre-
7 vious provisions of this subsection, an individual may
8 elect a high deductible/medisave product only during
9 an annual, coordinated election period described in
10 paragraph (3)(B) or during the month of October,
11 1996.

12 “(f) EFFECTIVENESS OF ELECTIONS.—

13 “(1) DURING INITIAL COVERAGE ELECTION PE-
14 RIOD.—An election of coverage made during the ini-
15 tial coverage election period under subsection
16 (e)(1)(A) shall take effect upon the date the individ-
17 ual becomes entitled to benefits under part A and
18 enrolled under part B, except as the Secretary may
19 provide (consistent with section 1838) in order to
20 prevent retroactive coverage.

21 “(2) DURING TRANSITION; 90-DAY
22 DISENROLLMENT OPTION.—An election of coverage
23 made under subsection (e)(2) and an election to dis-
24 continue a MedicarePlus option under subsection
25 (e)(4) at any time shall take effect with the first cal-

1 endar month following the date on which the election
2 is made.

3 “(3) ANNUAL, COORDINATED ELECTION PERIOD
4 AND MEDISAVE ELECTION.—An election of coverage
5 made during an annual, coordinated election period
6 (as defined in subsection (e)(3)(B)) in a year or for
7 a high deductible/medisave product shall take effect
8 as of the first day of the following year.

9 “(4) OTHER PERIODS.—An election of coverage
10 made during any other period under subsection
11 (e)(5) shall take effect in such manner as the Sec-
12 retary provides in a manner consistent (to the extent
13 practicable) with protecting continuity of health ben-
14 efit coverage.

15 “(g) EFFECT OF ELECTION OF MEDICAREPLUS OP-
16 TION.—Subject to the provisions of section 1855(f), pay-
17 ments under a contract with a MedicarePlus organization
18 under section 1858(a) with respect to an individual elect-
19 ing a MedicarePlus product offered by the organization
20 shall be instead of the amounts which (in the absence of
21 the contract) would otherwise be payable under parts A
22 and B for items and services furnished to the individual.

23 “(h) ADMINISTRATION.—

24 “(1) IN GENERAL.—This part and sections
25 1805 and 1876 shall be administered through an op-

1 erating division (A) that is established or identified
 2 by the Secretary in the Department of Health and
 3 Human Services, (B) that is separate from the
 4 Health Care Financing Administration, and (C) the
 5 primary function of which is the administration of
 6 this part and such sections. The director of such di-
 7 vision shall be of equal pay and rank to that of the
 8 individual responsible for overall administration of
 9 parts A and B.

10 “(2) TRANSFER AUTHORITY.—The Secretary
 11 shall transfer such personnel, administrative support
 12 systems, assets, records, funds, and other resources
 13 in the Health Care Financing Administration to the
 14 operating division referred to in paragraph (1) as
 15 are used in the administration of section 1876 and
 16 as may be required to implement the provisions re-
 17 ferred to in such paragraph promptly and effi-
 18 ciently.”.

19 **SEC. 15002. MEDICAREPLUS PROGRAM.**

20 (a) IN GENERAL.—Title XVIII is amended by redes-
 21 ignating part C as part D and by inserting after part B
 22 the following new part:

1 “PART C—PROVISIONS RELATING TO MEDICAREPLUS
2 “REQUIREMENTS FOR MEDICAREPLUS ORGANIZATIONS;
3 HIGH DEDUCTIBLE/MEDISAVE PRODUCTS

4 “SEC. 1851. (a) MEDICAREPLUS ORGANIZATION DE-
5 FINED.—In this part, subject to the succeeding provisions
6 of this section, the term ‘MedicarePlus organization’
7 means a public or private entity that is certified under
8 section 1857 as meeting the requirements and standards
9 of this part for such an organization.

10 “(b) ORGANIZED AND LICENSED UNDER STATE
11 LAW.—

12 “(1) IN GENERAL.—A MedicarePlus organiza-
13 tion shall be organized and licensed under State law
14 to offer health insurance or health benefits coverage
15 in each State in which it offers a MedicarePlus prod-
16 uct.

17 “(2) EXCEPTION FOR UNION AND TAFT-HART-
18 LEY SPONSORS.—Paragraph (1) shall not apply to
19 an MedicarePlus organization that is a union spon-
20 sor or a Taft-Hartley sponsor (as defined in section
21 1852(c)(4)).

22 “(3) EXCEPTION FOR PROVIDER-SPONSORED
23 ORGANIZATIONS.—Paragraph (1) shall not apply to
24 a MedicarePlus organization that is a provider-spon-

1 sored organization (as defined in section 1854(a))
2 except to the extent provided under section 1857(c).

3 “(4) EXCEPTION FOR QUALIFIED ASSOCIA-
4 TIONS.—Paragraph (1) shall not apply to a
5 MedicarePlus organization that is a qualified asso-
6 ciation (as defined in section 1852(c)(4)(C)).

7 “(c) PREPAID PAYMENT.—A MedicarePlus organiza-
8 tion shall be compensated (except for deductibles, coinsur-
9 ance, and copayments) for the provision of health care
10 services to enrolled members by a payment which is paid
11 on a periodic basis without regard to the date the health
12 care services are provided and which is fixed without re-
13 gard to the frequency, extent, or kind of health care serv-
14 ice actually provided to a member.

15 “(d) ASSUMPTION OF FULL FINANCIAL RISK.—The
16 MedicarePlus organization shall assume full financial risk
17 on a prospective basis for the provision of the health care
18 services (other than hospice care) for which benefits are
19 required to be provided under section 1852(a)(1), except
20 that the organization—

21 “(1) may obtain insurance or make other ar-
22 rangements for the cost of providing to any enrolled
23 member such services the aggregate value of which
24 exceeds \$5,000 in any year,

1 “(2) may obtain insurance or make other ar-
2 rangements for the cost of such services provided to
3 its enrolled members other than through the organi-
4 zation because medical necessity required their pro-
5 vision before they could be secured through the orga-
6 nization,

7 “(3) may obtain insurance or make other ar-
8 rangements for not more than 90 percent of the
9 amount by which its costs for any of its fiscal years
10 exceed 115 percent of its income for such fiscal year,
11 and

12 “(4) may make arrangements with physicians
13 or other health professionals, health care institu-
14 tions, or any combination of such individuals or in-
15 stitutions to assume all or part of the financial risk
16 on a prospective basis for the provision of basic
17 health services by the physicians or other health pro-
18 fessionals or through the institutions.

19 In the case of a MedicarePlus organization that is a union
20 sponsor (as defined in section 1852(c)(4)(A)), Taft-Hart-
21 ley sponsor (as defined in section 1852(c)(4)(B)), a quali-
22 fied association (as defined in section 1852(c)(4)(C)), this
23 subsection shall not apply with respect to MedicarePlus
24 products offered by such organization and issued by an
25 organization to which subsection (b)(1) applies or by a

1 provider-sponsored organization (as defined in section
2 1854(a)).

3 “(e) PROVISION AGAINST RISK OF INSOLVENCY.—

4 “(1) IN GENERAL.—Each MedicarePlus organi-
5 zation shall meet standards under section 1856 re-
6 lating to the financial solvency and capital adequacy
7 of the organization. Such standards shall take into
8 account the nature and type of MedicarePlus prod-
9 ucts offered by the organization.

10 “(2) TREATMENT OF UNION AND TAFT-HART-
11 LEY SPONSORS.—An entity that is a union sponsor
12 or a Taft-Hartley sponsor is deemed to meet the re-
13 quirement of paragraph (1).

14 “(3) TREATMENT OF CERTAIN QUALIFIED AS-
15 SOCIATIONS.—An entity that is a qualified associa-
16 tion is deemed to meet the requirement of paragraph
17 (1) with respect to MedicarePlus products offered by
18 such association and issued by an organization to
19 which subsection (b)(1) applies or by a provider-
20 sponsored organization.

21 “(f) HIGH DEDUCTIBLE/MEDISAVE PRODUCT DE-
22 FINED.—

23 “(1) IN GENERAL.—In this part, the term ‘high
24 deductible/medisave product’ means a MedicarePlus
25 product that—

1 “(A) provides reimbursement for at least
2 the items and services described in section
3 1852(a)(1) in a year but only after the enrollee
4 incurs countable expenses (as specified under
5 the product) equal to the amount of a deduct-
6 ible (described in paragraph (2));

7 “(B) counts as such expenses (for purposes
8 of such deductible) at least all amounts that
9 would have been payable under parts A and B
10 or by the enrollee if the enrollee had elected to
11 receive benefits through the provisions of such
12 parts; and

13 “(C) provides, after such deductible is met
14 for a year and for all subsequent expenses for
15 benefits referred to in subparagraph (A) in the
16 year, for a level of reimbursement that is not
17 less than—

18 “(i) 100 percent of such expenses, or

19 “(ii) 100 percent of the amounts that
20 would have been paid (without regard to
21 any deductibles or coinsurance) under
22 parts A and B with respect to such ex-
23 penses,

1 whichever is less. Such term does not include
2 the MedicarePlus MSA itself or any contribu-
3 tion into such account.

4 “(2) DEDUCTIBLE.—The amount of deductible
5 under a high deductible/medisave product—

6 “(A) for contract year 1997 shall be not
7 more than \$10,000; and

8 “(B) for a subsequent contract year shall
9 be not more than the maximum amount of such
10 deductible for the previous contract year under
11 this paragraph increased by the national aver-
12 age per capita growth rate under section
13 1855(c)(3) for the year.

14 If the amount of the deductible under subparagraph
15 (B) is not a multiple of \$50, the amount shall be
16 rounded to the nearest multiple of \$50.

17 “(g) ORGANIZATIONS TREATED AS MEDICAREPLUS
18 ORGANIZATIONS DURING TRANSITION.—Any of the fol-
19 lowing organizations shall be considered to qualify as a
20 MedicarePlus organization for contract years beginning
21 before January 1, 1998:

22 “(1) HEALTH MAINTENANCE ORGANIZA-
23 TIONS.—An organization that is organized under the
24 laws of any State and that is a qualified health
25 maintenance organization (as defined in section

1 1310(d) of the Public Health Service Act), an orga-
 2 nization recognized under State law as a health
 3 maintenance organization, or a similar organization
 4 regulated under State law for solvency in the same
 5 manner and to the same extent as such a health
 6 maintenance organization.

7 “(2) LICENSED INSURERS.—An organization
 8 that is organized under the laws of any State and—

9 “(A) is licensed by a State agency as an
 10 insurer for the offering of health benefit cov-
 11 erage, or

12 “(B) is licensed by a State agency as a
 13 service benefit plan,

14 but only for individuals residing in an area in which
 15 the organization is licensed to offer health insurance
 16 coverage.

17 “(3) CURRENT RISK-CONTRACTORS.—An orga-
 18 nization that is an eligible organization (as defined
 19 in section 1876(b)) and that has a risk-sharing con-
 20 tract in effect under section 1876 as of the date of
 21 the enactment of this section.

22 “(h) MEDIGRANT DEMONSTRATION PROJECTS.—
 23 The Secretary shall provide, in at least 10 States, for dem-
 24 onstration projects which would permit MediGrant pro-
 25 grams under title XXI to be treated as MedicarePlus orga-

1 nizations under this part for individuals who are qualified
 2 to elect the MedicarePlus option and who eligible to re-
 3 ceive medical assistance under the MediGrant program,
 4 for the purpose of demonstrating the delivery of primary,
 5 acute, and long-term care through an integrated delivery
 6 network which emphasizes noninstitutional care.

7 “REQUIREMENTS RELATING TO BENEFITS, PROVISION OF
 8 SERVICES, ENROLLMENT, AND PREMIUMS

9 “SEC. 1852. (a) BENEFITS COVERED.—

10 “(1) IN GENERAL.—Except as provided in sec-
 11 tion 1851(f)(1) with respect to high deductible/
 12 medisave products, each MedicarePlus product of-
 13 fered under this part shall provide benefits for at
 14 least the items and services for which benefits are
 15 available under parts A and B consistent with the
 16 standards for coverage of such items and services
 17 applicable under this title.

18 “(2) ORGANIZATION AS SECONDARY PAYER.—
 19 Notwithstanding any other provision of law, a
 20 MedicarePlus organization may (in the case of the
 21 provision of items and services to an individual
 22 under this part under circumstances in which pay-
 23 ment under this title is made secondary pursuant to
 24 section 1862(b)(2)) charge or authorize the provider
 25 of such services to charge, in accordance with the
 26 charges allowed under such law or policy—

1 “(A) the insurance carrier, employer, or
2 other entity which under such law, plan, or pol-
3 icy is to pay for the provision of such services,
4 or

5 “(B) such individual to the extent that the
6 individual has been paid under such law, plan,
7 or policy for such services.

8 “(3) SATISFACTION OF REQUIREMENT.—A
9 MedicarePlus product (other than a high deductible/
10 medisave product) offered by a MedicarePlus organi-
11 zation satisfies paragraph (1) with respect to bene-
12 fits for items and services if the following require-
13 ments are met:

14 “(A) FEE FOR SERVICE PROVIDERS.—In
15 the case of benefits furnished through a pro-
16 vider that does not have a contract with the or-
17 ganization, the product provides for at least the
18 dollar amount of payment for such items and
19 services as would otherwise be provided under
20 parts A and B.

21 “(B) PARTICIPATING PROVIDERS.—In the
22 case of benefits furnished through a provider
23 that has such a contract, the individual’s liabil-
24 ity for payment for such items and services
25 does not exceed (after taking into account any

1 deductible, which does not exceed any deduct-
 2 ible under parts A and B) the lesser of the fol-
 3 lowing:

4 “(i) NON-MEDICAREPLUS LIABIL-
 5 ITY.—The amount of the liability that the
 6 individual would have had (based on the
 7 provider being a participating provider) if
 8 the individual had elected the non-
 9 MedicarePlus option.

10 “(ii) MEDICARE COINSURANCE AP-
 11 PLIED TO PRODUCT PAYMENT RATES.—
 12 The applicable coinsurance or copayment
 13 rate (that would have applied under the
 14 non-MedicarePlus option) of the payment
 15 rate provided under the contract.

16 “(b) ANTIDISCRIMINATION.—A MedicarePlus organi-
 17 zation may not deny, limit, or condition the coverage or
 18 provision of benefits under this part based on the health
 19 status, claims experience, receipt of health care, medical
 20 history, or lack of evidence of insurability, of an individual.

21 “(c) GUARANTEED ISSUE AND RENEWAL.—

22 “(1) IN GENERAL.—Except as provided in this
 23 subsection, a MedicarePlus organization shall pro-
 24 vide that at any time during which elections are ac-
 25 cepted under section 1805 with respect to a

1 MedicarePlus product offered by the organization,
2 the organization will accept without restrictions indi-
3 viduals who are eligible to make such election.

4 “(2) PRIORITY.—If the Secretary determines
5 that a MedicarePlus organization, in relation to a
6 MedicarePlus product it offers, has a capacity limit
7 and the number of eligible individuals who elect the
8 product under section 1805 exceeds the capacity
9 limit, the organization may limit the election of indi-
10 viduals of the product under such section but only
11 if priority in election is provided—

12 “(A) first to such individuals as have elect-
13 ed the product at the time of the determination,
14 and

15 “(B) then to other such individuals in such
16 a manner that does not discriminate among the
17 individuals (who seek to elect the product) on a
18 basis described in subsection (b).

19 “(3) LIMITATION ON TERMINATION OF ELEC-
20 TION.—

21 “(A) IN GENERAL.—Subject to subpara-
22 graph (B), a MedicarePlus organization may
23 not for any reason terminate the election of any
24 individual under section 1805 for a
25 MedicarePlus product it offers.

1 “(B) BASIS FOR TERMINATION OF ELEC-
 2 TION.—A MedicarePlus organization may ter-
 3 minate an individual’s election under section
 4 1805 with respect to a MedicarePlus product it
 5 offers if—

6 “(i) any premiums required with re-
 7 spect to such product are not paid on a
 8 timely basis (consistent with standards
 9 under section 1856 that provide for a
 10 grace period for late payment of pre-
 11 miums),

12 “(ii) the individual has engaged in
 13 disruptive behavior (as specified in such
 14 standards), or

15 “(iii) the product is terminated with
 16 respect to all individuals under this part.

17 Any individual whose election is so terminated
 18 is deemed to have elected the Non-MedicarePlus
 19 option (as defined in section 1805(a)(3)(A)).

20 “(C) ORGANIZATION OBLIGATION WITH RE-
 21 SPECT TO ELECTION FORMS.—Pursuant to a con-
 22 tract under section 1858, each MedicarePlus organi-
 23 zation receiving an election form under section
 24 1805(c)(2) shall transmit to the Secretary (at such
 25 time and in such manner as the Secretary may

1 specify) a copy of such form or such other informa-
 2 tion respecting the election as the Secretary may
 3 specify.

4 “(4) SPECIAL RULES FOR LIMITED ENROLL-
 5 MENT MEDICAREPLUS ORGANIZATIONS.—

6 “(A) UNIONS.—

7 “(i) IN GENERAL.—Subject to sub-
 8 paragraph (D), a union sponsor (as de-
 9 fined in clause (ii)) shall limit eligibility of
 10 enrollees under this part for MedicarePlus
 11 products it offers to individuals who are
 12 members of the sponsor and affiliated with
 13 the sponsor through an employment rela-
 14 tionship with any employer or are the
 15 spouses of such members.

16 “(ii) UNION SPONSOR.—In this part
 17 and section 1805, the term ‘union sponsor’
 18 means an employee organization in relation
 19 to a group health plan that is established
 20 or maintained by the organization other
 21 than pursuant to a collective bargaining
 22 agreement.

23 “(B) TAFT-HARTLEY SPONSORS.—

24 “(i) IN GENERAL.—Subject to sub-
 25 paragraph (D), a MedicarePlus organiza-

tion that is a Taft-Hartley sponsor (as defined in clause (ii)) shall limit eligibility of enrollees under this part for MedicarePlus products it offers to individuals who are entitled to obtain benefits through such products under the terms of an applicable collective bargaining agreement.

“(ii) TAFT-HARTLEY SPONSOR.—In this part and section 1805, the term ‘Taft-Hartley sponsor’ means, in relation to a group health plan that is established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of parties who establish or maintain the plan.

“(C) QUALIFIED ASSOCIATIONS.—

“(i) IN GENERAL.—Subject to subparagraph (D), a MedicarePlus organization that is a qualified association (as defined in clause (iii)) shall limit eligibility of individuals under this part for products it offers to individuals who are members of

1 the association (or who are spouses of such
2 individuals).

3 “(ii) LIMITATION ON TERMINATION
4 OF COVERAGE.—Such a qualifying associa-
5 tion offering a MedicarePlus product to an
6 individual may not terminate coverage of
7 the individual on the basis that the individ-
8 ual is no longer a member of the associa-
9 tion except pursuant to a change of elec-
10 tion during an open election period occur-
11 ring on or after the date of the termination
12 of membership.

13 “(iii) QUALIFIED ASSOCIATION.—In
14 this part and section 1805, the term ‘quali-
15 fied association’ means an association, reli-
16 gious fraternal organization, or other orga-
17 nization (which may be a trade, industry,
18 or professional association, a chamber of
19 commerce, or a public entity association)
20 that the Secretary finds—

21 “(I) has been formed for pur-
22 poses other than the sale of any
23 health insurance and does not restrict
24 membership based on the health sta-
25 tus, claims experience, receipt of

1 health care, medical history, or lack of
2 evidence of insurability, of an individ-
3 ual,

4 “(II) does not exist solely or
5 principally for the purpose of selling
6 insurance, and

7 “(III) has at least 1,000 individ-
8 ual members or 200 employer mem-
9 bers.

10 Such term includes a subsidiary or cor-
11 poration that is wholly owned by one or
12 more qualified organizations.

13 “(D) LIMITATION.—Rules of eligibility to
14 carry out the previous subparagraphs of this
15 paragraph shall not have the effect of denying
16 eligibility to individuals on the basis of health
17 status, claims experience, receipt of health care,
18 medical history, or lack of evidence of insurabil-
19 ity.

20 “(E) LIMITED ENROLLMENT MEDICARE-
21 PLUS ORGANIZATION.—In this part and section
22 1805, the term ‘limited enrollment
23 MedicarePlus organization’ means a
24 MedicarePlus organization that is a union spon-

1 sor, a Taft-Hartley sponsor, or a qualified asso-
2 ciation.

3 “(F) EMPLOYER, ETC.—In this paragraph,
4 the terms ‘employer’, ‘employee organization’,
5 and ‘group health plan’ have the meanings
6 given such terms for purposes of part 6 of sub-
7 title B of title I of the Employee Retirement In-
8 come Security Act of 1974.

9 “(d) SUBMISSION AND CHARGING OF PREMIUMS.—

10 “(1) IN GENERAL.—Each MedicarePlus organi-
11 zation shall file with the Secretary each year, in a
12 form and manner and at a time specified by the Sec-
13 retary—

14 “(A) the amount of the monthly premiums
15 for coverage under each MedicarePlus product
16 it offers under this part in each payment area
17 (as determined for purposes of section 1855) in
18 which the product is being offered; and

19 “(B) the enrollment capacity in relation to
20 the product in each such area.

21 “(2) AMOUNTS OF PREMIUMS CHARGED.—The
22 amount of the monthly premium charged by a
23 MedicarePlus organization for a MedicarePlus prod-
24 uct offered in a payment area to an individual under

1 this part shall be equal to the amount (if any) by
2 which—

3 “(A) the amount of the monthly premium
4 for the product for the period involved, as es-
5 tablished under paragraph (3) and submitted
6 under paragraph (1), exceeds

7 “(B)(i) $\frac{1}{12}$ of the annual MedicarePlus
8 capitation rate specified in section 1855(b)(2)
9 for the area and period involved, or (ii) in the
10 case of a high deductible/medisave product, the
11 monthly adjusted MedicarePlus capitation rate
12 specified in section 1855(b)(1) for the individ-
13 ual and period involved.

14 “(3) UNIFORM PREMIUM.—

15 “(A) IN GENERAL.—Except as provided in
16 subparagraph (B), the premiums charged by a
17 MedicarePlus organization under this part may
18 not vary among individuals who reside in the
19 same payment area.

20 “(B) EXCEPTION FOR HIGH DEDUCTIBLE/
21 MEDISAVE PRODUCTS.—A MedicarePlus organi-
22 zation shall establish premiums for any high de-
23 ductible/medisave product it offers in a payment
24 area based on each of the risk adjustment cat-
25 egories established for purposes of determining

1 the amount of the payment to MedicarePlus or-
 2 ganizations under section 1855(b)(1) and using
 3 the identical demographic and other adjust-
 4 ments among such categories as are used for
 5 such purposes.

6 “(4) TERMS AND CONDITIONS OF IMPOSING
 7 PREMIUMS.—Each MedicarePlus organization shall
 8 permit the payment of monthly premiums on a
 9 monthly basis and may terminate election of individ-
 10 uals for a MedicarePlus product for failure to make
 11 premium payments only in accordance with sub-
 12 section (c)(3)(B).

13 “(5) RELATION OF PREMIUMS AND COST-SHAR-
 14 ING TO BENEFITS.—In no case may the portion of
 15 a MedicarePlus organization’s premium rate and the
 16 actuarial value of its deductibles, coinsurance, and
 17 copayments charged (to the extent attributable to
 18 the minimum benefits described in subsection (a)(1)
 19 and not counting any amount attributable to balance
 20 billing) to individuals who are enrolled under this
 21 part with the organization exceed the actuarial value
 22 of the coinsurance and deductibles that would be ap-
 23 plicable on the average to individuals enrolled under
 24 this part with the organization (or, if the Secretary
 25 finds that adequate data are not available to deter-

1 mine that actuarial value, the actuarial value of the
 2 coinsurance and deductibles applicable on the aver-
 3 age to individuals in the area, in the State, or in the
 4 United States, eligible to enroll under this part with
 5 the organization, or other appropriate data) and en-
 6 titled to benefits under part A and enrolled under
 7 part B if they were not members of a MedicarePlus
 8 organization.

9 “(e) REQUIREMENT FOR ADDITIONAL BENEFITS,
 10 PART B PREMIUM DISCOUNT REBATES, OR BOTH.—

11 “(1) REQUIREMENT.—

12 “(A) IN GENERAL.—Each MedicarePlus
 13 organization (in relation to a MedicarePlus
 14 product it offers) shall provide that if there is
 15 an excess amount (as defined in subparagraph
 16 (B)) for the product for a contract year, subject
 17 to the succeeding provisions of this subsection,
 18 the organization shall provide to individuals
 19 such additional benefits (as the organization
 20 may specify), a monetary rebate (paid on a
 21 monthly basis) of the part B monthly premium,
 22 or a combination thereof, in a total value which
 23 is at least equal to the adjusted excess amount
 24 (as defined in subparagraph (C)).

1 “(B) EXCESS AMOUNT.—For purposes of
2 this paragraph, the ‘excess amount’, for an or-
3 ganization for a product, is the amount (if any)
4 by which—

5 “(i) the average of the capitation pay-
6 ments made to the organization under this
7 part for the product at the beginning of
8 contract year, exceeds

9 “(ii) the actuarial value of the mini-
10 mum benefits described in subsection
11 (a)(1) under the product for individuals
12 under this part, as determined based upon
13 an adjusted community rate described in
14 paragraph (5) (as reduced for the actuarial
15 value of the coinsurance and deductibles
16 under parts A and B).

17 “(C) ADJUSTED EXCESS AMOUNT.—For
18 purposes of this paragraph, the ‘adjusted excess
19 amount’, for an organization for a product, is
20 the excess amount reduced to reflect any
21 amount withheld and reserved for the organiza-
22 tion for the year under paragraph (3).

23 “(D) NO APPLICATION TO HIGH DEDUCT-
24 IBLE/MEDISAVE PRODUCT.—Subparagraph (A)

1 shall not apply to a high deductible/medisave
2 product.

3 “(E) UNIFORM APPLICATION.—This para-
4 graph shall be applied uniformly for all enroll-
5 ees for a product in a service area.

6 “(F) CONSTRUCTION.—Nothing in this
7 subsection shall be construed as preventing a
8 MedicarePlus organization from providing
9 health care benefits that are in addition to the
10 benefits otherwise required to be provided under
11 this paragraph and from imposing a premium
12 for such additional benefits.

13 “(2) LIMITATION ON AMOUNT OF PART B PRE-
14 MIUM DISCOUNT REBATE.—In no case shall the
15 amount of a part B premium discount rebate under
16 paragraph (1)(A) exceed, with respect to a month,
17 the amount of premiums imposed under part B (not
18 taking into account section 1839(b) (relating to pen-
19 alty for late enrollment) or 1839(h) (relating to af-
20 fluence testing)), for the individual for the month.
21 Except as provided in the previous sentence, a
22 MedicarePlus organization is not authorized to pro-
23 vide for cash or other monetary rebates as an in-
24 ducement for enrollment or otherwise.

1 “(3) STABILIZATION FUND.—A MedicarePlus
2 organization may provide that a part of the value of
3 an excess actuarial amount described in paragraph
4 (1) be withheld and reserved in the Federal Hospital
5 Insurance Trust Fund and in the Federal Supple-
6 mentary Medical Insurance Trust Fund (in such
7 proportions as the Secretary determines to be appro-
8 priate) by the Secretary for subsequent annual con-
9 tract periods, to the extent required to stabilize and
10 prevent undue fluctuations in the additional benefits
11 and rebates offered in those subsequent periods by
12 the organization in accordance with such paragraph.
13 Any of such value of amount reserved which is not
14 provided as additional benefits described in para-
15 graph (1)(A) to individuals electing the
16 MedicarePlus product in accordance with such para-
17 graph prior to the end of such periods, shall revert
18 for the use of such trust funds.

19 “(4) DETERMINATION BASED ON INSUFFICIENT
20 DATA.—For purposes of this subsection, if the Sec-
21 retary finds that there is insufficient enrollment ex-
22 perience (including no enrollment experience in the
23 case of a provider-sponsored organization) to deter-
24 mine an average of the capitation payments to be
25 made under this part at the beginning of a contract

1 period, the Secretary may determine such an aver-
 2 age based on the enrollment experience of other con-
 3 tracts entered into under this part.

4 “(5) ADJUSTED COMMUNITY RATE.—

5 “(A) IN GENERAL.—For purposes of this
 6 subsection, subject to subparagraph (B), the
 7 term ‘adjusted community rate’ for a service or
 8 services means, at the election of a
 9 MedicarePlus organization, either—

10 “(i) the rate of payment for that serv-
 11 ice or services which the Secretary annu-
 12 ally determines would apply to an individ-
 13 ual electing a MedicarePlus product under
 14 this part if the rate of payment were deter-
 15 mined under a ‘community rating system’
 16 (as defined in section 1302(8) of the Pub-
 17 lic Health Service Act, other than subpara-
 18 graph (C)), or

19 “(ii) such portion of the weighted ag-
 20 gregate premium, which the Secretary an-
 21 nually estimates would apply to such an in-
 22 dividual, as the Secretary annually esti-
 23 mates is attributable to that service or
 24 services,

1 but adjusted for differences between the utiliza-
 2 tion characteristics of the individuals electing
 3 coverage under this part and the utilization
 4 characteristics of the other enrollees with the
 5 organization (or, if the Secretary finds that
 6 adequate data are not available to adjust for
 7 those differences, the differences between the
 8 utilization characteristics of individuals select-
 9 ing other MedicarePlus coverage, or individuals
 10 in the area, in the State, or in the United
 11 States, eligible to elect MedicarePlus coverage
 12 under this part and the utilization characteris-
 13 tics of the rest of the population in the area, in
 14 the State, or in the United States, respectively).

15 “(B) SPECIAL RULE FOR PROVIDER-SPON-
 16 SORED ORGANIZATIONS.—In the case of a
 17 MedicarePlus organization that is a provider-
 18 sponsored organization, the adjusted community
 19 rate under subparagraph (A) for a
 20 MedicarePlus product may be computed (in a
 21 manner specified by the Secretary) using data
 22 in the general commercial marketplace or (dur-
 23 ing a transition period) based on the costs in-
 24 curred by the organization in providing such a
 25 product.

1 “(f) RULES REGARDING PHYSICIAN PARTICIPA-
2 TION.—

3 “(1) PROCEDURES.—Each MedicarePlus orga-
4 nization shall establish reasonable procedures relat-
5 ing to the participation (under an agreement be-
6 tween a physician and the organization) of physi-
7 cians under MedicarePlus products offered by the
8 organization under this part. Such procedures shall
9 include—

10 “(A) providing notice of the rules regard-
11 ing participation,

12 “(B) providing written notice of participa-
13 tion decisions that are adverse to physicians,
14 and

15 “(C) providing a process within the organi-
16 zation for appealing adverse decisions, including
17 the presentation of information and views of the
18 physician regarding such decision.

19 “(2) CONSULTATION IN MEDICAL POLICIES.—A
20 MedicarePlus organization shall consult with physi-
21 cians who have entered into participation agree-
22 ments with the organization regarding the organiza-
23 tion’s medical policy, quality, and medical manage-
24 ment procedures.

1 “(3) LIMITATIONS ON PHYSICIAN INCENTIVE
2 PLANS.—

3 “(A) IN GENERAL.—Each MedicarePlus
4 organization may not operate any physician in-
5 centive plan (as defined in subparagraph (B))
6 unless the following requirements are met:

7 “(i) No specific payment is made di-
8 rectly or indirectly under the plan to a
9 physician or physician group as an induce-
10 ment to reduce or limit medically necessary
11 services provided with respect to a specific
12 individual enrolled with the organization.

13 “(ii) If the plan places a physician or
14 physician group at substantial financial
15 risk (as determined by the Secretary) for
16 services not provided by the physician or
17 physician group, the organization—

18 “(I) provides stop-loss protection
19 for the physician or group that is ade-
20 quate and appropriate, based on
21 standards developed by the Secretary
22 that take into account the number of
23 physicians placed at such substantial
24 financial risk in the group or under
25 the plan and the number of individ-

1 uals enrolled with the organization
2 who receive services from the physi-
3 cian or the physician group, and

4 “(II) conducts periodic surveys of
5 both individuals enrolled and individ-
6 uals previously enrolled with the orga-
7 nization to determine the degree of
8 access of such individuals to services
9 provided by the organization and sat-
10 isfaction with the quality of such serv-
11 ices.

12 “(iii) The organization provides the
13 Secretary with descriptive information re-
14 garding the plan, sufficient to permit the
15 Secretary to determine whether the plan is
16 in compliance with the requirements of this
17 subparagraph.

18 “(B) PHYSICIAN INCENTIVE PLAN DE-
19 FINED.—In this paragraph, the term ‘physician
20 incentive plan’ means any compensation ar-
21 rangement between a MedicarePlus organiza-
22 tion and a physician or physician group that
23 may directly or indirectly have the effect of re-
24 ducing or limiting services provided with respect

1 to individuals enrolled with the organization
2 under this part.

3 “(4) LIMITATION ON PROVIDER INDEMNIFICA-
4 TION.—A MedicarePlus organization may not pro-
5 vide (directly or indirectly) for a provider (or group
6 of providers) to indemnify the organization against
7 any liability resulting from a civil action brought by
8 or on behalf of an enrollee under this part for any
9 damage caused to the enrollee by the organization’s
10 denial of medically necessary care.

11 “(5) EXCEPTION FOR CERTAIN FEE-FOR-SERV-
12 ICE PLANS.—The previous provisions of this sub-
13 section shall not apply in the case of a MedicarePlus
14 organization in relation to a MedicarePlus product if
15 the organization does not have agreements between
16 physicians and the organization for the provision of
17 benefits under the product.

18 “(g) PROVISION OF INFORMATION.—A MedicarePlus
19 organization shall provide the Secretary with such infor-
20 mation on the organization and each MedicarePlus prod-
21 uct it offers as may be required for the preparation of
22 the information booklet described in section
23 1805(d)(3)(A).

24 “(h) COORDINATED ACUTE AND LONG-TERM CARE
25 BENEFITS UNDER A MEDICAREPLUS PRODUCT.—Noth-

1 ing in this part shall be construed as preventing a State
 2 from coordinating benefits under its MediGrant program
 3 under title XXI with those provided under a MedicarePlus
 4 product in a manner that assures continuity of a full-
 5 range of acute care and long-term care services to poor
 6 elderly or disabled individuals eligible for benefits under
 7 this title and under such program.

8 “(i) TRANSITIONAL FILE AND USE FOR CERTAIN
 9 REQUIREMENTS.—

10 “(1) IN GENERAL.—In the case of a
 11 MedicarePlus product proposed to be offered before
 12 the end of the transition period (as defined in sec-
 13 tion 1805(e)(1)(B)), by a MedicarePlus organization
 14 described in section 1851(g)(3) or by a
 15 MedicarePlus organization with a contract in effect
 16 under section 1858, if the organization submits com-
 17 plete information to the Secretary regarding the
 18 product demonstrating that the product meets the
 19 requirements and standards under subsections (a),
 20 (d), and (e) (relating to benefits and premiums), the
 21 product shall be deemed as meeting such require-
 22 ments and standards under such subsections unless
 23 the Secretary disapproves the product within 60
 24 days after the date of submission of the complete in-
 25 formation.

1 “(2) CONSTRUCTION.—Nothing in paragraph
2 (1) shall be construed as waiving the requirement of
3 a contract under section 1858 or waiving require-
4 ments and standards not referred to in paragraph
5 (1).

6 “PATIENT PROTECTION STANDARDS

7 “SEC. 1853. (a) DISCLOSURE TO ENROLLEES.—A
8 MedicarePlus organization shall disclose in clear, accurate,
9 and standardized form, information regarding all of the
10 following for each MedicarePlus product it offers:

11 “(1) Benefits under the MedicarePlus product
12 offered, including exclusions from coverage and, if it
13 is a high deductible/medisave product, a comparison
14 of benefits under such a product with benefits under
15 other MedicarePlus products.

16 “(2) Rules regarding prior authorization or
17 other review requirements that could result in
18 nonpayment.

19 “(3) Potential liability for cost-sharing for out-
20 of-network services.

21 “(4) The number, mix, and distribution of par-
22 ticipating providers.

23 “(5) The financial obligations of the enrollee,
24 including premiums, deductibles, co-payments, and
25 maximum limits on out-of-pocket losses for items
26 and services (both in and out of network).

1 “(6) Statistics on enrollee satisfaction with the
2 product and organization, including rates of
3 reenrollment.

4 “(7) Enrollee rights and responsibilities, includ-
5 ing the grievance process provided under subsection
6 (f).

7 “(8) A statement that the use of the 911 emer-
8 gency telephone number is appropriate in emergency
9 situations and an explanation of what constitutes an
10 emergency situation.

11 “(9) A description of the organization’s quality
12 assurance program under subsection (d).

13 Such information shall be disclosed to each enrollee under
14 this part at the time of enrollment and at least annually
15 thereafter.

16 “(b) ACCESS TO SERVICES.—

17 “(1) IN GENERAL.—A MedicarePlus organiza-
18 tion offering a MedicarePlus product may restrict
19 the providers from whom the benefits under the
20 product are provided so long as—

21 “(A) the organization makes such benefits
22 available and accessible to each individual elect-
23 ing the product within the product service area
24 with reasonable promptness and in a manner

1 which assures continuity in the provision of
2 benefits;

3 “(B) when medically necessary the organi-
4 zation makes such benefits available and acces-
5 sible 24 hours a day and 7 days a week;

6 “(C) the product provides for reimburse-
7 ment with respect to services which are covered
8 under subparagraphs (A) and (B) and which
9 are provided to such an individual other than
10 through the organization, if—

11 “(i) the services were medically nec-
12 essary and immediately required because of
13 an unforeseen illness, injury, or condition,
14 and

15 “(ii) it was not reasonable given the
16 circumstances to obtain the services
17 through the organization; and

18 “(D) coverage is provided for emergency
19 services (as defined in paragraph (4)) without
20 regard to prior authorization or the emergency
21 care provider’s contractual relationship with the
22 organization.

23 “(2) MINIMUM PAYMENT LEVELS WHERE PRO-
24 VIDING POINT-OF-SERVICE COVERAGE.—If a
25 MedicarePlus product provides benefits for items

1 and services (not described in paragraph (1)(C))
 2 through a network of providers and also permits
 3 payment to be made under the product for such
 4 items and services not provided through such a net-
 5 work, the payment level under the product with re-
 6 spect to such items and services furnished outside
 7 the network shall be at least 70 percent (or, if the
 8 effective cost-sharing rate is 50 percent, at least 40
 9 percent) of the lesser of—

10 “(A) the payment basis (determined with-
 11 out regard to deductibles and cost-sharing) that
 12 would have applied for such items and services
 13 under parts A and B, or

14 “(B) the amount charged by the entity fur-
 15 nishing such items and services.

16 “(3) PROTECTION OF ENROLLEES FOR CERTAIN
 17 EMERGENCY SERVICES.—

18 “(A) PARTICIPATING PROVIDERS.—In the
 19 case of emergency services described in sub-
 20 paragraph (C) which are furnished by a partici-
 21 pating physician or provider of services to an
 22 individual enrolled with a MedicarePlus organi-
 23 zation under this section, the applicable partici-
 24 pation agreement is deemed to provide that the
 25 physician or provider of services will accept as

1 payment in full from the organization for such
 2 emergency services described in subparagraph
 3 (C) the amount that would be payable to the
 4 physician or provider of services under part B
 5 and from the individual under such part, if the
 6 individual were not enrolled with such an orga-
 7 nization under this part.

8 “(B) NONPARTICIPATING PROVIDERS.—In
 9 the case of emergency services described in sub-
 10 paragraph (C) which are furnished by a
 11 nonparticipating physician, the limitations on
 12 actual charges for such services otherwise appli-
 13 cable under part B (to services furnished by in-
 14 dividuals not enrolled with a MedicarePlus or-
 15 ganization under this section) shall apply in the
 16 same manner as such limitations apply to serv-
 17 ices furnished to individuals not enrolled with
 18 such an organization.

19 “(C) EMERGENCY SERVICES DESCRIBED.—
 20 The emergency services described in this sub-
 21 paragraph are emergency services which are
 22 furnished to an enrollee of a MedicarePlus or-
 23 ganization under this part by a physician or
 24 provider of services that is not under a contract
 25 with the organization.

1 “(D) EXCEPTION FOR CERTAIN FEE-FOR-
 2 SERVICE PLANS.—The previous provisions of
 3 this paragraph shall not apply in the case of a
 4 MedicarePlus organization in relation to a
 5 MedicarePlus product if the organization does
 6 not have agreements between physicians and
 7 the organization for the provision of benefits
 8 under the product.

9 “(4) DEFINITION OF EMERGENCY SERVICES.—
 10 In this subsection, the term ‘emergency services’
 11 means, with respect to an individual enrolled with an
 12 organization, covered inpatient and outpatient serv-
 13 ices that—

14 “(A) are furnished by an appropriate
 15 source other than the organization,

16 “(B) are needed immediately because of an
 17 injury or sudden illness, and

18 “(C) are needed because the time required
 19 to reach the organization’s providers or suppli-
 20 ers would have meant risk of serious damage to
 21 the patient’s health.

22 “(c) CONFIDENTIALITY AND ACCURACY OF EN-
 23 ROLLEE RECORDS.—Each MedicarePlus organization
 24 shall establish procedures—

1 “(1) to safeguard the privacy of individually
2 identifiable enrollee information, and

3 “(2) to maintain accurate and timely medical
4 records for enrollees.

5 “(d) QUALITY ASSURANCE PROGRAM.—

6 “(1) IN GENERAL.—Each MedicarePlus organi-
7 zation must have arrangements, established in ac-
8 cordance with regulations of the Secretary, for an
9 ongoing quality assurance program for health care
10 services it provides to such individuals.

11 “(2) ELEMENTS OF PROGRAM.—The quality as-
12 surance program shall—

13 “(A) stress health outcomes;

14 “(B) provide for the establishment of writ-
15 ten protocols for utilization review, based on
16 current standards of medical practice;

17 “(C) provide review by physicians and
18 other health care professionals of the process
19 followed in the provision of such health care
20 services;

21 “(D) monitors and evaluates high volume
22 and high risk services and the care of acute and
23 chronic conditions;

24 “(E) evaluates the continuity and coordi-
25 nation of care that enrollees receive;

1 “(F) has mechanisms to detect both under-
2 utilization and overutilization of services;

3 “(G) after identifying areas for improve-
4 ment, establishes or alters practice parameters;

5 “(H) takes action to improve quality and
6 assesses the effectiveness of such action
7 through systematic follow-up;

8 “(I) makes available information on quality
9 and outcomes measures to facilitate beneficiary
10 comparison and choice of health coverage op-
11 tions (in such form and on such quality and
12 outcomes measures as the Secretary determines
13 to be appropriate);

14 “(J) is evaluated on an ongoing basis as to
15 its effectiveness; and

16 “(K) provide for external accreditation or
17 review, by a utilization and quality control peer
18 review organization under part B of title XI or
19 other qualified independent review organization,
20 of the quality of services furnished by the orga-
21 nization meets professionally recognized stand-
22 ards of health care (including providing ade-
23 quate access of enrollees to services).

24 “(3) EXCEPTION FOR CERTAIN FEE-FOR-SERV-
25 ICE PLANS.—Paragraph (1) and subsection (c)(2)

1 shall not apply in the case of a MedicarePlus organi-
 2 zation in relation to a MedicarePlus product to the
 3 extent the organization provides for coverage of ben-
 4 efits without restrictions relating to utilization and
 5 without regard to whether the provider has a con-
 6 tract or other arrangement with the plan for the
 7 provision of such benefits.

8 “(4) TREATMENT OF ACCREDITATION.—The
 9 Secretary shall provide that a MedicarePlus organi-
 10 zation is deemed to meet the requirements of para-
 11 graphs (1) and (2) of this subsection and subsection
 12 (c) if the organization is accredited (and periodically
 13 reaccredited) by a private organization under a proc-
 14 ess that the Secretary has determined assures that
 15 the organization meets standards that are no less
 16 stringent than the standards established under sec-
 17 tion 1856 to carry out this subsection and sub-
 18 section (c).

19 “(e) COVERAGE DETERMINATIONS.—

20 “(1) DECISIONS ON NONEMERGENCY CARE.—A
 21 MedicarePlus organization shall make determina-
 22 tions regarding authorization requests for non-
 23 emergency care on a timely basis, depending on the
 24 urgency of the situation.

25 “(2) APPEALS.—

1 “(A) IN GENERAL.—Appeals from a deter-
2 mination of an organization denying coverage
3 shall be decided within 30 days of the date of
4 receipt of medical information, but not later
5 than 60 days after the date of the decision.

6 “(B) PHYSICIAN DECISION ON CERTAIN
7 APPEALS.—Appeal decisions relating to a deter-
8 mination to deny coverage based on a lack of
9 medical necessity shall be made only by a physi-
10 cian.

11 “(C) EMERGENCY CASES.—Appeals from
12 such a determination involving a life-threaten-
13 ing or emergency situation shall be decided on
14 an expedited basis.

15 “(f) GRIEVANCES AND APPEALS.—

16 “(1) GRIEVANCE MECHANISM.—Each
17 MedicarePlus organization must provide meaningful
18 procedures for hearing and resolving grievances be-
19 tween the organization (including any entity or indi-
20 vidual through which the organization provides
21 health care services) and enrollees under this part.

22 “(2) APPEALS.—An enrollee with an organiza-
23 tion under this part who is dissatisfied by reason of
24 the enrollee’s failure to receive any health service to
25 which the enrollee believes the enrollee is entitled

1 and at no greater charge than the enrollee believes
 2 the enrollee is required to pay is entitled, if the
 3 amount in controversy is \$100 or more, to a hearing
 4 before the Secretary to the same extent as is pro-
 5 vided in section 205(b), and in any such hearing the
 6 Secretary shall make the organization a party. If the
 7 amount in controversy is \$1,000 or more, the indi-
 8 vidual or organization shall, upon notifying the other
 9 party, be entitled to judicial review of the Sec-
 10 retary's final decision as provided in section 205(g),
 11 and both the individual and the organization shall be
 12 entitled to be parties to that judicial review. In ap-
 13 plying sections 205(b) and 205(g) as provided in
 14 this subparagraph, and in applying section 205(l)
 15 thereto, any reference therein to the Commissioner
 16 of Social Security or the Social Security Administra-
 17 tion shall be considered a reference to the Secretary
 18 or the Department of Health and Human Services,
 19 respectively.

20 “(3) INDEPENDENT REVIEW OF CERTAIN COV-
 21 ERAGE DENIALS.—The Secretary shall contract with
 22 an independent, outside entity to review and resolve
 23 appeals of denials of coverage related to urgent or
 24 emergency services with respect to MedicarePlus
 25 products.

1 “(4) COORDINATION WITH SECRETARY OF
2 LABOR.—The Secretary shall consult with the Sec-
3 retary of Labor so as to ensure that the require-
4 ments of this subsection, as they apply in the case
5 of grievances referred to in paragraph (1) to which
6 section 503 of the Employee Retirement Income Se-
7 curity Act of 1974 applies, are applied in a manner
8 consistent with the requirements of such section
9 503.

10 “(g) INFORMATION ON ADVANCE DIRECTIVES.—
11 Each MedicarePlus organization shall meet the require-
12 ment of section 1866(f) (relating to maintaining written
13 policies and procedures respecting advance directives).

14 “(h) APPROVAL OF MARKETING MATERIALS.—

15 “(1) SUBMISSION.—Each MedicarePlus organi-
16 zation may not distribute marketing materials un-
17 less—

18 “(A) at least 45 days before the date of
19 distribution the organization has submitted the
20 material to the Secretary for review, and

21 “(B) the Secretary has not disapproved the
22 distribution of such material.

23 “(2) REVIEW.—The standards established
24 under section 1856 shall include guidelines for the
25 review of all such material submitted and under

1 such guidelines the Secretary shall disapprove such
2 material if the material is materially inaccurate or
3 misleading or otherwise makes a material misrepre-
4 sentation.

5 “(3) DEEMED APPROVAL (1-STOP SHOPPING).—
6 In the case of material that is submitted under para-
7 graph (1)(A) to the Secretary or a regional office of
8 the Department of Health and Human Services and
9 the Secretary or the office has not disapproved the
10 distribution of marketing materials under paragraph
11 (1)(B) with respect to a MedicarePlus product in an
12 area, the Secretary is deemed not to have dis-
13 approved such distribution in all other areas covered
14 by the product and organization.

15 “(4) PROHIBITION OF CERTAIN MARKETING
16 PRACTICES.—Each MedicarePlus organization shall
17 conform to fair marketing standards in relation to
18 MedicarePlus products offered under this part, in-
19 cluded in the standards established under section
20 1856. Such standards shall include a prohibition
21 against an organization (or agent of such an organi-
22 zation) completing any portion of any election form
23 under section 1805 on behalf of any individual.

24 “PROVIDER-SPONSORED ORGANIZATIONS
25 “SEC. 1854. (a) PROVIDER-SPONSORED ORGANIZA-
26 TION DEFINED.—

1 “(1) IN GENERAL.—In this part, the term ‘pro-
2 vider-sponsored organization’ means a public or pri-
3 vate entity that (in accordance with standards estab-
4 lished under subsection (b)) is a provider, or group
5 of affiliated providers, that provides a substantial
6 proportion (as defined by the Secretary under such
7 standards) of the health care items and services
8 under the contract under this part directly through
9 the provider or affiliated group of providers.

10 “(2) SUBSTANTIAL PROPORTION.—In defining
11 what is a ‘substantial proportion’ for purposes of
12 paragraph (1), the Secretary—

13 “(A) shall take into account the need for
14 such an organization to assume responsibility
15 for a substantial proportion of services in order
16 to assure financial stability and the practical
17 difficulties in such an organization integrating
18 a very wide range of service providers; and

19 “(B) may vary such proportion based upon
20 relevant differences among organizations, such
21 as their location in an urban or rural area.

22 “(3) AFFILIATION.—For purposes of this sub-
23 section, a provider is ‘affiliated’ with another pro-
24 vider if, through contract, ownership, or otherwise—

1 “(A) one provider, directly or indirectly,
2 controls, is controlled by, or is under common
3 control with the other,

4 “(B) each provider is a participant in a
5 lawful combination under which each provider
6 shares, directly or indirectly, substantial finan-
7 cial risk in connection with their operations,

8 “(C) both providers are part of a con-
9 trolled group of corporations under section
10 1563 of the Internal Revenue Code of 1986, or

11 “(D) both providers are part of an affili-
12 ated service group under section 414 of such
13 Code.

14 “(4) CONTROL.—For purposes of paragraph
15 (3), control is presumed to exist if one party, di-
16 rectly or indirectly, owns, controls, or holds the
17 power to vote, or proxies for, not less than 51 per-
18 cent of the voting rights or governance rights of an-
19 other.

20 “(b) PROCESS FOR ESTABLISHING STANDARDS FOR
21 PROVIDER-SPONSORED ORGANIZATIONS.—For process of
22 establishing of standards for provider-sponsored organiza-
23 tions, see section 1856(c).

24 “(c) PROCESS FOR STATE CERTIFICATION OF PRO-
25 VIDER-SPONSORED ORGANIZATIONS.—For process of

1 State certification of provider-sponsored organizations, see
2 section 1857(c).

3 “(d) PREEMPTION OF STATE INSURANCE LICENSING
4 REQUIREMENTS.—

5 “(1) IN GENERAL.—This section supersedes
6 any State law which—

7 “(A) requires that a provider-sponsored or-
8 ganization meet requirements for insurers of
9 health services or health maintenance organiza-
10 tions doing business in the State with respect to
11 initial capitalization and establishment of finan-
12 cial reserves against insolvency, or

13 “(B) imposes requirements that would
14 have the effect of prohibiting the organization
15 from complying with the applicable require-
16 ments of this part,

17 insofar as such the law applies to individuals en-
18 rolled with the organization under this part.

19 “(2) EXCEPTION.—Paragraph (1) shall not
20 apply with respect to any State law to the extent
21 that such law provides standards or requirements, or
22 provides for enforcement thereof, so as to meet the
23 requirements of section 1857(c)(2) with respect to
24 approval by the Secretary of State certification re-
25 quirements thereunder.

1 “(3) CONSTRUCTION.—Nothing in this sub-
2 section shall be construed as affecting the operation
3 of section 514 of the Employee Retirement Income
4 Security Act of 1974.

5 “PAYMENTS TO MEDICAREPLUS ORGANIZATIONS

6 “SEC. 1855. (a) PAYMENTS.—

7 “(1) IN GENERAL.—Under a contract under
8 section 1858 the Secretary shall pay to each
9 MedicarePlus organization, with respect to coverage
10 of an individual under this part in a payment area
11 for a month, an amount equal to the monthly ad-
12 justed MedicarePlus capitation rate (as provided
13 under subsection (b)) with respect to that individual
14 for that area.

15 “(2) ANNUAL ANNOUNCEMENT.—The Secretary
16 shall annually determine, and shall announce (in a
17 manner intended to provide notice to interested par-
18 ties) not later than September 7 before the calendar
19 year concerned—

20 “(A) the annual MedicarePlus capitation
21 rate for each payment area for the year, and

22 “(B) the factors to be used in adjusting
23 such rates under subsection (b) for payments
24 for months in that year.

25 “(3) ADVANCE NOTICE OF METHODOLOGICAL
26 CHANGES.—At least 45 days before making the an-

1 nouncement under paragraph (2) for a year, the
 2 Secretary shall provide for notice to MedicarePlus
 3 organizations of proposed changes to be made in the
 4 methodology or benefit coverage assumptions from
 5 the methodology and assumptions used in the pre-
 6 vious announcement and shall provide such organi-
 7 zations an opportunity to comment on such proposed
 8 changes.

9 “(4) EXPLANATION OF ASSUMPTIONS.—In each
 10 announcement made under paragraph (2) for a year,
 11 the Secretary shall include an explanation of the as-
 12 sumptions (including any benefit coverage assump-
 13 tions) and changes in methodology used in the an-
 14 nouncement in sufficient detail so that MedicarePlus
 15 organizations can compute monthly adjusted
 16 MedicarePlus capitation rates for classes of individ-
 17 uals located in each payment area which is in whole
 18 or in part within the service area of such an organi-
 19 zation.

20 “(b) MONTHLY ADJUSTED MEDICAREPLUS CAPITA-
 21 TION RATE.—

22 “(1) IN GENERAL.—For purposes of this sec-
 23 tion, the ‘monthly adjusted MedicarePlus capitation
 24 rate’ under this subsection, for a month in a year
 25 for an individual in a payment area (specified under

1 paragraph (3)) and in a class (established under
2 paragraph (4)), is $\frac{1}{12}$ of the annual MedicarePlus
3 capitation rate specified in paragraph (2) for that
4 area for the year, adjusted to reflect the actuarial
5 value of benefits under this title with respect to indi-
6 viduals in such class compared to the national aver-
7 age for individuals in all classes.

8 “(2) ANNUAL MEDICAREPLUS CAPITATION
9 RATES.—For purposes of this section, the annual
10 MedicarePlus capitation rate for a payment area for
11 a year is equal to the annual MedicarePlus capita-
12 tion rate for the area for the previous year (or, in
13 the case of 1996, the average annual per capita rate
14 of payment described in section 1876(a)(1)(C) for
15 the area for 1995) increased by the per capita
16 growth rate for that area and year (as determined
17 under subsection (c)).

18 “(3) PAYMENT AREA DEFINED.—In this sec-
19 tion, the term ‘payment area’ means a county (or
20 equivalent area specified by the Secretary), except
21 that in the case of the population group described in
22 paragraph (5)(C), the payment area shall be each
23 State.

24 “(4) CLASSES.—

1 “(A) IN GENERAL.—For purposes of this
2 section, the Secretary shall define appropriate
3 classes of enrollees, consistent with paragraph
4 (5), based on age, gender, welfare status, insti-
5 tutionalization, and such other factors as the
6 Secretary determines to be appropriate, so as to
7 ensure actuarial equivalence. The Secretary
8 may add to, modify, or substitute for such
9 classes, if such changes will improve the deter-
10 mination of actuarial equivalence.

11 “(B) RESEARCH.—The Secretary shall
12 conduct such research as may be necessary to
13 provide for greater accuracy in the adjustment
14 of capitation rates under this subsection. Such
15 research may include research into the addition
16 or modification of classes under subparagraph
17 (A). The Secretary shall submit to Congress a
18 report on such research by not later than Janu-
19 ary 1, 1997.

20 “(5) DIVISION OF MEDICARE POPULATION.—In
21 carrying out paragraph (4) and this section, the Sec-
22 retary shall recognize the following separate popu-
23 lation groups:

1 “(A) AGED.—Individuals 65 years of age
2 or older who are not described in subparagraph
3 (C).

4 “(B) DISABLED.—Disabled individuals
5 who are under 65 years of age and not de-
6 scribed in subparagraph (C).

7 “(C) INDIVIDUALS WITH END STAGE
8 RENAL DISEASE.—Individuals who are deter-
9 mined to have end stage renal disease.

10 “(c) PER CAPITA GROWTH RATES.—

11 “(1) FOR 1996.—

12 “(A) IN GENERAL.—For purposes of this
13 section and subject to subparagraph (B), the
14 per capita growth rates for 1996, for a payment
15 area assigned to a service utilization cohort
16 under subsection (d), shall be the following:

17 “(i) LOWEST SERVICE UTILIZATION
18 COHORT.—For areas assigned to the low-
19 est service utilization cohort, 9.7 percent
20 plus the additional percent provided under
21 subparagraph (B)(ii).

22 “(ii) LOWER SERVICE UTILIZATION
23 COHORT.—For areas assigned to the lower
24 service utilization cohort, 8.0 percent.

1 “(iii) MEDIAN SERVICE UTILIZATION
2 COHORT.—For areas assigned to the me-
3 dian service utilization cohort, 5.1 percent.

4 “(iv) HIGHER SERVICE UTILIZATION
5 COHORT.—For areas assigned to the high-
6 er service utilization cohort, 4.7 percent.

7 “(v) HIGHEST SERVICE UTILIZATION
8 COHORT.—For areas assigned to the high-
9 est service utilization cohort, 4.0 percent.

10 “(B) BUDGET NEUTRAL ADJUSTMENT.—
11 In order to assure that the total capitation pay-
12 ments under this section during 1996 are the
13 same as the amount such payments would have
14 been if the per capita growth rate for all such
15 areas for 1996 were equal to the national aver-
16 age per capita growth rate, specified in para-
17 graph (3) for 1996, the Secretary shall adjust
18 the per capita growth rates for payment areas
19 as follows:

20 “(i) INCREASE UP TO FLOOR FOR
21 LOWEST SERVICE UTILIZATION COHORT.—
22 First, such additional percent increase as
23 may be necessary to assure that the annual
24 MedicarePlus capitation rate for each pay-

1 ment area is at least 12 times \$250 for
2 1996.

3 “(ii) RESIDUAL INCREASE TO LOWEST
4 SERVICE UTILIZATION COHORT.—Next, for
5 payment areas assigned to the lowest serv-
6 ice utilization cohort, such additional per-
7 cent increase as will assure that the total
8 capitation payments under this section
9 during 1996 are the same as the amount
10 such payments would have been if the per
11 capita growth rate for all such areas for
12 1996 were equal to the national average
13 per capita growth rate. The increase under
14 this clause may apply to a payment area
15 described in clause (i) and shall be applied
16 after the increase provided under such
17 clause.

18 “(2) FOR SUBSEQUENT YEARS.—

19 “(A) IN GENERAL.—For purposes of this
20 section and subject to subparagraph (B), the
21 Secretary shall compute a per capita growth
22 rate for each year after 1996, for each payment
23 area as assigned to a service utilization cohort
24 under subsection (d), consistent with the follow-
25 ing rules:

1 “(i) MEDIAN SERVICE UTILIZATION
2 COHORT SET AT NATIONAL AVERAGE PER
3 CAPITA GROWTH RATE.—The per capita
4 growth rate for areas assigned to the me-
5 dian service utilization cohort for the year
6 shall be the national average per capita
7 growth rate for the year (as specified
8 under paragraph (3)), subject to subpara-
9 graph (C).

10 “(ii) HIGHEST SERVICE UTILIZATION
11 COHORT SET AT 75 PERCENT OF NA-
12 TIONAL AVERAGE PER CAPITA GROWTH
13 RATE.—The per capita growth rate for
14 areas assigned to the highest service utili-
15 zation cohort for the year shall be 75 per-
16 cent of the national average per capita
17 growth rate for the year.

18 “(iii) LOWEST SERVICE UTILIZATION
19 COHORT SET AT 187.5 PERCENT OF NA-
20 TIONAL AVERAGE PER CAPITA GROWTH
21 RATE.—The per capita growth rate for
22 areas assigned to the lowest service utiliza-
23 tion cohort for the year shall be 187.5 per-
24 cent of the national average per capita

growth rate for the year, subject to subparagraph (C).

“(iv) LOWER SERVICE UTILIZATION COHORT SET AT 150 PERCENT OF NATIONAL AVERAGE PER CAPITA GROWTH RATE.—

“(I) IN GENERAL.—Subject to subclause (II), the per capita growth rate for areas assigned to the lower service utilization cohort for the year shall be 150 percent of the national average per capita growth rate for the year.

“(II) ADJUSTMENT.—If the Secretary has established under clause (v) the per capita growth rate for areas assigned to the higher service utilization cohort for the year at 75 percent of the national average per capita growth rate, the Secretary may provide for a reduced per capita growth rate under subclause (I) to the extent necessary to comply with subparagraph (B).

1 “(v) HIGHER SERVICE UTILIZATION
2 COHORT.—The per capita growth rate for
3 areas assigned to the higher service utiliza-
4 tion cohort for the year shall be such per-
5 cent (not less than 75 percent) of the na-
6 tional average per capita growth rate, as
7 the Secretary may determine consistent
8 with subparagraph (B).

9 “(B) AVERAGE PER CAPITA GROWTH RATE
10 AT NATIONAL AVERAGE TO ASSURE BUDGET
11 NEUTRALITY.—The Secretary shall compute per
12 capita growth rates for a year under subpara-
13 graph (A) (before the application of subpara-
14 graph (C)) in a manner so that the weighted
15 average per capita growth rate for all areas for
16 the year (weighted to reflect the number of
17 medicare beneficiaries in each area) is equal to
18 the national average per capita growth rate
19 under paragraph (3) for the year.

20 “(C) FINAL ADJUSTMENT OF GROWTH
21 RATES.—After computing per capita growth
22 rates under the previous provisions of this para-
23 graph the Secretary shall—

24 “(i) reduce the per capita growth rate
25 for areas assigned to the median service

1 utilization cohort by the ratio of .1 to 5.3,
2 and

3 “(ii) increase the per capita growth
4 rate for areas assigned to the lowest serv-
5 ice utilization cohort by such proportion as
6 the Secretary determines will result in an
7 increase in outlays resulting from this
8 clause equal to the reduction in outlays re-
9 sulting from clause (i) for the year in-
10 volved.

11 “(3) NATIONAL AVERAGE PER CAPITA GROWTH
12 RATES.—In this subsection, the ‘national average
13 per capita growth rate’ for—

14 “(A) 1996 is 5.3 percent,

15 “(B) 1997 is 3.8 percent,

16 “(C) 1998 is 4.6 percent,

17 “(D) 1999 is 4.3 percent,

18 “(E) 2000 is 3.8 percent,

19 “(F) 2001 is 5.5 percent,

20 “(G) 2002 is 5.6 percent, and

21 “(H) each subsequent year is 5.0 percent.

22 “(d) ASSIGNMENT OF PAYMENT AREAS TO SERVICE
23 UTILIZATION COHORTS.—

24 “(1) IN GENERAL.—For purposes of determin-
25 ing per capita growth rates under subsection (c) for

1 areas for a year, the Secretary shall assign each pay-
 2 ment area to a service utilization cohort (based on
 3 the service utilization index value for that area de-
 4 termined under paragraph (2)) as follows:

5 “(A) LOWEST SERVICE UTILIZATION CO-
 6 HORT.—Areas with a service utilization index
 7 value of less than .80 shall be assigned to the
 8 lowest service utilization cohort.

9 “(B) LOWER SERVICE UTILIZATION CO-
 10 HORT.—Areas with a service utilization index
 11 value of at least .80 but less than .90 shall be
 12 assigned to the lower service utilization cohort.

13 “(C) MEDIAN SERVICE UTILIZATION CO-
 14 HORT.—Areas with a service utilization index
 15 value of at least .90 but less than 1.10 shall be
 16 assigned to the median service utilization co-
 17 hort.

18 “(D) HIGHER SERVICE UTILIZATION CO-
 19 HORT.—Areas with a service utilization index
 20 value of at least 1.10 but less than 1.20 shall
 21 be assigned to the higher service utilization co-
 22 hort.

23 “(E) HIGHEST SERVICE UTILIZATION CO-
 24 HORT.—Areas with a service utilization index

1 value of at least 1.20 shall be assigned to the
2 highest service utilization cohort.

3 “(2) DETERMINATION OF SERVICE UTILIZATION
4 INDEX VALUES.—In order to determine the per cap-
5 ita growth rate for a payment area for each year
6 (beginning with 1996), the Secretary shall determine
7 for such area and year a service utilization index
8 value, which is equal to—

9 “(A) the annual MedicarePlus capitation
10 rate under this section for the area for the year
11 in which the determination is made (or, in the
12 case of 1996, the average annual per capita
13 rate of payment (described in section
14 1876(a)(1)(C)) for the area for 1995); divided
15 by

16 “(B) the input-price-adjusted annual na-
17 tional MedicarePlus capitation rate (as deter-
18 mined under paragraph (3)) for that area for
19 the year in which the determination is made.

20 “(3) DETERMINATION OF INPUT-PRICE-AD-
21 JUSTED RATES.—

22 “(A) IN GENERAL.—For purposes of para-
23 graph (2), the ‘input-price-adjusted annual na-
24 tional MedicarePlus capitation rate’ for a pay-
25 ment area for a year is equal to the sum, for

1 all the types of medicare services (as classified
2 by the Secretary), of the product (for each such
3 type) of—

4 “(i) the national standardized
5 MedicarePlus capitation rate (determined
6 under subparagraph (B)) for the year,

7 “(ii) the proportion of such rate for
8 the year which is attributable to such type
9 of services, and

10 “(iii) an index that reflects (for that
11 year and that type of services) the relative
12 input price of such services in the area
13 compared to the national average input
14 price of such services.

15 In applying clause (iii), the Secretary shall, sub-
16 ject to subparagraph (C), apply those indices
17 under this title that are used in applying (or
18 updating) national payment rates for specific
19 areas and localities.

20 “(B) NATIONAL STANDARDIZED
21 MEDICAREPLUS CAPITATION RATE.—In this
22 paragraph, the ‘national standardized
23 MedicarePlus capitation rate’ for a year is
24 equal to—

1 “(i) the sum (for all payment areas)
 2 of the product of (I) the annual
 3 MedicarePlus capitation rate for that year
 4 for the area under subsection (b)(2), and
 5 (II) the average number of medicare bene-
 6 ficiaries residing in that area in the year;
 7 divided by

8 “(ii) the total average number of med-
 9 icare beneficiaries residing in all the pay-
 10 ment areas for that year.

11 “(C) SPECIAL RULES FOR 1996.—In apply-
 12 ing this paragraph for 1996—

13 “(i) medicare services shall be divided
 14 into 2 types of services: part A services
 15 and part B services;

16 “(ii) the proportions described in sub-
 17 paragraph (A)(ii) for such types of services
 18 shall be—

19 “(I) for part A services, the ratio
 20 (expressed as a percentage) of the av-
 21 erage annual per capita rate of pay-
 22 ment for the area for part A for 1995
 23 to the total average annual per capita
 24 rate of payment for the area for parts
 25 A and B for 1995, and

1 “(II) for part B services, 100
2 percent minus the ratio described in
3 subclause (I);

4 “(iii) for the part A services, 70 per-
5 cent of payments attributable to such serv-
6 ices shall be adjusted by the index used
7 under section 1886(d)(3)(E) to adjust pay-
8 ment rates for relative hospital wage levels
9 for hospitals located in the payment area
10 involved;

11 “(iv) for part B services—

12 “(I) 66 percent of payments at-
13 tributable to such services shall be ad-
14 justed by the index of the geographic
15 area factors under section 1848(e)
16 used to adjust payment rates for phy-
17 sicians’ services furnished in the pay-
18 ment area, and

19 “(II) of the remaining 34 percent
20 of the amount of such payments, 70
21 percent shall be adjusted by the index
22 described in clause (iii);

23 “(v) the index values shall be com-
24 puted based only on the beneficiary popu-
25 lation described in subsection (b)(5)(A).

1 The Secretary may continue to apply the rules
2 described in this subparagraph (or similar
3 rules) for 1997.

4 “(e) PAYMENT PROCESS.—

5 “(1) IN GENERAL.—Subject to subsection (f),
6 the Secretary shall make monthly payments under
7 this section in advance and in accordance with the
8 rate determined under subsection (a) to the plan for
9 each individual enrolled with a MedicarePlus organi-
10 zation under this part.

11 “(2) ADJUSTMENT TO REFLECT NUMBER OF
12 ENROLLEES.—

13 “(A) IN GENERAL.—The amount of pay-
14 ment under this subsection may be retroactively
15 adjusted to take into account any difference be-
16 tween the actual number of individuals enrolled
17 with an organization under this part and the
18 number of such individuals estimated to be so
19 enrolled in determining the amount of the ad-
20 vance payment.

21 “(B) SPECIAL RULE FOR CERTAIN EN-
22 ROLLEES.—

23 “(i) IN GENERAL.—Subject to clause
24 (ii), the Secretary may make retroactive
25 adjustments under subparagraph (A) to

1 take into account individuals enrolled dur-
 2 ing the period beginning on the date on
 3 which the individual enrolls with a
 4 MedicarePlus organization under a product
 5 operated, sponsored, or contributed to by
 6 the individual’s employer or former em-
 7 ployer (or the employer or former employer
 8 of the individual’s spouse) and ending on
 9 the date on which the individual is enrolled
 10 in the organization under this part, except
 11 that for purposes of making such retro-
 12 active adjustments under this subpara-
 13 graph, such period may not exceed 90
 14 days.

15 “(ii) EXCEPTION.—No adjustment
 16 may be made under clause (i) with respect
 17 to any individual who does not certify that
 18 the organization provided the individual
 19 with the disclosure statement described in
 20 section 1853(a) at the time the individual
 21 enrolled with the organization.

22 “(f) SPECIAL RULES FOR INDIVIDUALS ELECTING
 23 HIGH DEDUCTIBLE/MEDISAVE PRODUCT.—

24 “(1) IN GENERAL.—In the case of an individual
 25 who has elected a high deductible/medisave product,

1 notwithstanding the preceding provisions of this sec-
2 tion—

3 “(A) the amount of the payment to the
4 MedicarePlus organization offering the high de-
5 ductible/medisave product shall not exceed the
6 premium for the product, and

7 “(B) subject to paragraph (2), the dif-
8 ference between the amount of payment that
9 would otherwise be made and the amount of
10 payment to such organization shall be made di-
11 rectly into a MedicarePlus MSA established
12 (and, if applicable, designated) by the individual
13 under paragraph (2).

14 “(2) ESTABLISHMENT AND DESIGNATION OF
15 MEDICAREPLUS MEDICAL SAVINGS ACCOUNT AS RE-
16 QUIREMENT FOR PAYMENT OF CONTRIBUTION.—In
17 the case of an individual who has elected coverage
18 under a high deductible/medisave product, no pay-
19 ment shall be made under paragraph (1)(B) on be-
20 half of an individual for a month unless the individ-
21 ual—

22 “(A) has established before the beginning
23 of the month (or by such other deadline as the
24 Secretary may specify) a MedicarePlus MSA

1 (as defined in section 137(b) of the Internal
2 Revenue Code of 1986), and

3 “(B) if the individual has established more
4 than one MedicarePlus MSA, has designated
5 one of such accounts as the individual’s
6 MedicarePlus MSA for purposes of this part.

7 Under rules under this section, such an individual
8 may change the designation of such account under
9 subparagraph (B) for purposes of this part.

10 “(3) LUMP SUM DEPOSIT OF MEDICAL SAVINGS
11 ACCOUNT CONTRIBUTION.—In the case of an indi-
12 vidual electing a high deductible/medisave product
13 effective beginning with a month in a year, the
14 amount of the contribution to the MedicarePlus
15 MSA on behalf of the individual for that month and
16 all successive months in the year shall be deposited
17 during that first month. In the case of a termination
18 of such an election as of a month before the end of
19 a year, the Secretary shall provide for a procedure
20 for the recovery of deposits attributable to the re-
21 maining months in the year.

22 “(g) PAYMENTS FROM TRUST FUND.—The payment
23 to a MedicarePlus organization under this section for indi-
24 viduals enrolled under this part with the organization, and
25 payments to a MedicarePlus MSA under subsection

1 (f)(1)(B), shall be made from the Federal Hospital Insur-
 2 ance Trust Fund and the Federal Supplementary Medical
 3 Insurance Trust Fund in such proportion as the Secretary
 4 determines reflects the relative weight that benefits under
 5 part A and under part B represents of the actuarial value
 6 of the total benefits under this title.

7 “(h) SPECIAL RULE FOR CERTAIN INPATIENT HOS-
 8 PITAL STAYS.—In the case of an individual who is receiv-
 9 ing inpatient hospital services from a subsection (d) hos-
 10 pital (as defined in section 1886(d)(1)(B)) as of the effec-
 11 tive date of the individual’s—

12 “(1) election under this part of a MedicarePlus
 13 product offered by a MedicarePlus organization—

14 “(A) payment for such services until the
 15 date of the individual’s discharge shall be made
 16 under this title through the MedicarePlus prod-
 17 uct or Non-MedicarePlus option (as the case
 18 may be) elected before the election with such
 19 organization,

20 “(B) the elected organization shall not be
 21 financially responsible for payment for such
 22 services until the date after the date of the indi-
 23 vidual’s discharge, and

1 “(C) the organization shall nonetheless be
2 paid the full amount otherwise payable to the
3 organization under this part; or

4 “(2) termination of election with respect to a
5 MedicarePlus organization under this part—

6 “(A) the organization shall be financially
7 responsible for payment for such services after
8 such date and until the date of the individual’s
9 discharge,

10 “(B) payment for such services during the
11 stay shall not be made under section 1886(d) or
12 by any succeeding MedicarePlus organization,
13 and

14 “(C) the terminated organization shall not
15 receive any payment with respect to the individ-
16 ual under this part during the period the indi-
17 vidual is not enrolled.

18 “ESTABLISHMENT OF STANDARDS FOR MEDICARE-PLUS
19 ORGANIZATIONS AND PRODUCTS

20 “SEC. 1856. (a) STANDARDS APPLICABLE TO STATE-
21 REGULATED ORGANIZATIONS AND PRODUCTS.—

22 “(1) RECOMMENDATIONS OF NAIC.—The Sec-
23 retary shall request the National Association of In-
24 surance Commissioners to develop and submit to the
25 Secretary, not later than 12 months after the date
26 of the enactment of the Medicare Preservation Act

1 of 1995, proposed standards consistent with the re-
 2 quirements of this part for MedicarePlus organiza-
 3 tions (other than union sponsors, Taft-Hartley spon-
 4 sors, and provider-sponsored organizations) and
 5 MedicarePlus products offered by such organiza-
 6 tions, except that such proposed standards may re-
 7 late to MedicarePlus organizations that are qualified
 8 associations only with respect to MedicarePlus prod-
 9 ucts offered by them and only if such products are
 10 issued by organizations to which section 1851(b)(1)
 11 applies.

12 “(2) REVIEW.—If the Association submits such
 13 standards on a timely basis, the Secretary shall re-
 14 view such standards to determine if the standards
 15 meet the requirements of the part. The Secretary
 16 shall complete the review of the standards not later
 17 than 90 days after the date of their submission. The
 18 Secretary shall promulgate such proposed standards
 19 to apply to organizations and products described in
 20 paragraph (1) except to the extent that the Sec-
 21 retary modifies such proposed standards because
 22 they do not meet such requirements.

23 “(3) FAILURE TO SUBMIT.—If the Association
 24 does not submit such standards on a timely basis,
 25 the Secretary shall promulgate such standards by

1 not later than the date the Secretary would other-
2 wise have been required to promulgate standards
3 under paragraph (2).

4 “(4) USE OF INTERIM RULES.—For the period
5 in which this part is in effect and standards are
6 being developed and established under the preceding
7 provisions of this subsection, the Secretary shall pro-
8 vide by not later than June 1, 1996, for the applica-
9 tion of such interim standards (without regard to
10 any requirements for notice and public comment) as
11 may be appropriate to provide for the expedited im-
12 plementation of this part. Such interim standards
13 shall not apply after the date standards are estab-
14 lished under the preceding provisions of this sub-
15 section.

16 “(b) UNION AND TAFT-HARTLEY SPONSORS, QUALI-
17 FIED ASSOCIATIONS, AND PRODUCTS.—

18 “(1) IN GENERAL.—The Secretary shall develop
19 and promulgate by regulation standards consistent
20 with the requirements of this part for union and
21 Taft-Hartley sponsors, for qualified associations,
22 and for MedicarePlus products offered by such orga-
23 nizations (other than MedicarePlus products offered
24 by qualified associations that are issued by organiza-
25 tions to which section 1851(b)(1) applies).

1 “(2) CONSULTATION WITH LABOR.—The Sec-
2 retary shall consult with the Secretary of Labor with
3 respect to such standards for such sponsors and
4 products.

5 “(3) TIMING.—Standards under this subsection
6 shall be promulgated at or about the time standards
7 are promulgated under subsection (a).

8 “(c) ESTABLISHMENT OF STANDARDS FOR PRO-
9 VIDER-SPONSORED ORGANIZATIONS.—

10 “(1) IN GENERAL.—The Secretary shall estab-
11 lish, on an expedited basis and using a negotiated
12 rulemaking process under subchapter 3 of chapter 5
13 of title 5, United States Code, standards that enti-
14 ties must meet to qualify as provider-sponsored or-
15 ganizations under this part.

16 “(2) PUBLICATION OF NOTICE.—In carrying
17 out the rulemaking process under this subsection,
18 the Secretary, after consultation with the National
19 Association of Insurance Commissioners, the Amer-
20 ican Academy of Actuaries, organizations represent-
21 ative of medicare beneficiaries, and other interested
22 parties, shall publish the notice provided for under
23 section 564(a) of title 5, United States Code, by not
24 later than 45 days after the date of the enactment
25 of Medicare Preservation Act of 1995.

1 “(3) TARGET DATE FOR PUBLICATION OF
2 RULE.—As part of the notice under paragraph (2),
3 and for purposes of this subsection, the ‘target date
4 for publication’ (referred to in section 564(a)(5) of
5 such title) shall be September 1, 1996.

6 “(4) ABBREVIATED PERIOD FOR SUBMISSION
7 OF COMMENTS.—In applying section 564(c) of such
8 title under this subsection, ‘15 days’ shall be sub-
9 stituted for ‘30 days’.

10 “(5) APPOINTMENT OF NEGOTIATED RULE-
11 MAKING COMMITTEE AND FACILITATOR.—The Sec-
12 retary shall provide for—

13 “(A) the appointment of a negotiated rule-
14 making committee under section 565(a) of such
15 title by not later than 30 days after the end of
16 the comment period provided for under section
17 564(c) of such title (as shortened under para-
18 graph (4)), and

19 “(B) the nomination of a facilitator under
20 section 566(c) of such title by not later than 10
21 days after the date of appointment of the com-
22 mittee.

23 “(6) PRELIMINARY COMMITTEE REPORT.—The
24 negotiated rulemaking committee appointed under
25 paragraph (5) shall report to the Secretary, by not

1 later than June 1, 1996, regarding the committee's
 2 progress on achieving a consensus with regard to the
 3 rulemaking proceeding and whether such consensus
 4 is likely to occur before one month before the target
 5 date for publication of the rule. If the committee re-
 6 ports that the committee has failed to make signifi-
 7 cant progress towards such consensus or is unlikely
 8 to reach such consensus by the target date, the Sec-
 9 retary may terminate such process and provide for
 10 the publication of a rule under this subsection
 11 through such other methods as the Secretary may
 12 provide.

13 “(7) FINAL COMMITTEE REPORT.—If the com-
 14 mittee is not terminated under paragraph (6), the
 15 rulemaking committee shall submit a report contain-
 16 ing a proposed rule by not later than one month be-
 17 fore the target publication date.

18 “(8) INTERIM, FINAL EFFECT.—The Secretary
 19 shall publish a rule under this subsection in the Fed-
 20 eral Register by not later than the target publication
 21 date. Such rule shall be effective and final imme-
 22 diately on an interim basis, but is subject to change
 23 and revision after public notice and opportunity for
 24 a period (of not less than 60 days) for public com-
 25 ment. In connection with such rule, the Secretary

1 shall specify the process for the timely review and
2 approval of applications of entities to be certified as
3 provider-sponsored organizations pursuant to such
4 rules and consistent with this subsection.

5 “(9) PUBLICATION OF RULE AFTER PUBLIC
6 COMMENT.—The Secretary shall provide for consid-
7 eration of such comments and republication of such
8 rule by not later than 1 year after the target publi-
9 cation date.

10 “(10) PROCESS FOR APPROVAL OF APPLICA-
11 TIONS FOR CERTIFICATION.—

12 “(A) IN GENERAL.—The Secretary shall
13 establish a process for the receipt and approval
14 of applications of entities for certification as
15 provider-sponsored organizations under this
16 part. Under such process, the Secretary shall
17 act upon a complete application submitted with-
18 in 60 days after the date it is received.

19 “(B) CIRCULATION OF PROPOSED APPLI-
20 CATION FORM.—By March 1, 1996, the Sec-
21 retary, after consultation with the negotiated
22 rulemaking committee, shall circulate a pro-
23 posed application form that could be used by
24 entities considering becoming certified as a pro-
25 vider-sponsored organization under this part.

1 “(d) COORDINATION AMONG FINAL STANDARDS.—In
 2 establishing standards (other than on an interim basis)
 3 under the previous provisions of this section, the Secretary
 4 shall seek to provide for consistency (as appropriate)
 5 across the different types of MedicarePlus organizations,
 6 in order to promote equitable treatment of different types
 7 of organizations and consistent protection for individuals
 8 who elect products offered by the different types of
 9 MedicarePlus organizations.

10 “(e) USE OF CURRENT STANDARDS FOR INTERIM
 11 STANDARDS.—To the extent practicable and consistent
 12 with the requirements of this part, standards established
 13 on an interim basis to carry out requirements of this part
 14 may be based on currently applicable standards, such as
 15 the rules established under section 1876 (as in effect as
 16 of the date of the enactment of this section) to carry out
 17 analogous provisions of such section or standards estab-
 18 lished or developed for application in the private health
 19 insurance market.

20 “(f) APPLICATION OF NEW STANDARDS TO ENTITIES
 21 WITH A CONTRACT.—In the case of a MedicarePlus orga-
 22 nization with a contract in effect under this part at the
 23 time standards applicable to the organization under this
 24 section are changed, the organization may elect not to
 25 have such changes apply to the organization until the end

1 of the current contract year (or, if there is less than 6
2 months remaining in the contract year, until 1 year after
3 the end of the current contract year).

4 “(g) RELATION TO STATE LAWS.—The standards es-
5 tablished under this section shall supersede any State law
6 or regulation with respect to MedicarePlus products which
7 are offered by MedicarePlus organizations and are issued
8 by organizations to which section 1851(b)(1) applies, to
9 the extent such law or regulation is inconsistent with such
10 standards.

11 “MEDICARE-PLUS CERTIFICATION

12 “SEC. 1857. (a) STATE CERTIFICATION PROCESS
13 FOR STATE-REGULATED ORGANIZATIONS.—

14 “(1) APPROVAL OF STATE PROCESS.—The Sec-
15 retary shall approve a MedicarePlus certification and
16 enforcement program established by a State for ap-
17 plying the standards established under section 1856
18 to MedicarePlus organizations (other than union
19 sponsors, Taft-Hartley sponsors, and provider-spon-
20 sored organizations) and MedicarePlus products of-
21 fered by such organizations if the Secretary deter-
22 mines that the program effectively provides for the
23 application and enforcement of such standards in
24 the State with respect to such organizations and
25 products. Such program shall provide for certifi-
26 cation of compliance of MedicarePlus organizations

1 and products with the applicable requirements of
2 this part not less often than once every 3 years.

3 “(2) EFFECT OF CERTIFICATION UNDER STATE
4 PROCESS.—A MedicarePlus organization and
5 MedicarePlus product offered by such an organiza-
6 tion that is certified under such program is consid-
7 ered to have been certified under this subsection
8 with respect to the offering of the product to individ-
9 uals residing in the State.

10 “(3) USER FEES.—The State may impose user
11 fees on organizations seeking certification under this
12 subsection in such amounts as the State deems suffi-
13 cient to finance the costs of such certification. Noth-
14 ing in this paragraph shall be construed as restrict-
15 ing a State’s authority to impose premium taxes,
16 other taxes, or other levies.

17 “(4) REVIEW.—The Secretary periodically shall
18 review State programs approved under paragraph
19 (1) to determine if they continue to provide for cer-
20 tification and enforcement described in such para-
21 graph. If the Secretary finds that a State program
22 no longer so provides, before making a final deter-
23 mination, the Secretary shall provide the State an
24 opportunity to adopt such a plan of correction as
25 would permit the State program to meet the require-

1 ments of paragraph (1). If the Secretary makes a
2 final determination that the State program, after
3 such an opportunity, fails to meet such require-
4 ments, the provisions of subsection (b) shall apply to
5 MedicarePlus organizations and products in the
6 State.

7 “(5) EFFECT OF NO STATE PROGRAM.—Begin-
8 ning on the date standards are established under
9 section 1856, in the case of organizations and prod-
10 ucts in States in which a certification program has
11 not been approved and in operation under paragraph
12 (1), the Secretary shall establish a process for the
13 certification of MedicarePlus organizations (other
14 than union sponsors, Taft-Hartley sponsors, and
15 provider-sponsored organizations) and products of
16 such organizations as meeting such standards.

17 “(6) PUBLICATION OF LIST OF APPROVED
18 STATE PROGRAMS.—The Secretary shall publish
19 (and periodically update) a list of those State pro-
20 grams which are approved for purposes of this sub-
21 section.

22 “(b) FEDERAL CERTIFICATION PROCESS FOR UNION
23 SPONSORS, TAFT-HARTLEY SPONSORS, AND PROVIDER-
24 SPONSORED ORGANIZATIONS.—

1 “(1) ESTABLISHMENT.—The Secretary shall es-
2 tablish a process for the certification of union spon-
3 sors, Taft-Hartley sponsors, and provider-sponsored
4 organizations and MedicarePlus products offered by
5 such sponsors and organizations as meeting the ap-
6 plicable standards established under section 1856.

7 “(2) INVOLVEMENT OF SECRETARY OF
8 LABOR.—Such process shall be established and oper-
9 ated in cooperation with the Secretary of Labor with
10 respect to union sponsors and Taft-Hartley spon-
11 sors.

12 “(3) USE OF STATE LICENSING AND PRIVATE
13 ACCREDITATION PROCESSES.—

14 “(A) IN GENERAL.—The process under
15 this subsection shall, to the maximum extent
16 practicable, provide that MedicarePlus organi-
17 zations and products that are licensed or cer-
18 tified through a qualified private accreditation
19 process that the Secretary finds applies stand-
20 ards that are no less stringent than the require-
21 ments of this part are deemed to meet the cor-
22 responding requirements of this part for such
23 an organization or product.

24 “(B) PERIODIC ACCREDITATION.—The use
25 of an accreditation under subparagraph (A)

1 shall be valid only for such period as the Sec-
2 retary specifies.

3 “(4) USER FEES.—The Secretary may impose
4 user fees on entities seeking certification under this
5 subsection in such amounts as the Secretary deems
6 sufficient to finance the costs of such certification.

7 “(c) CERTIFICATION OF PROVIDER-SPONSORED OR-
8 GANIZATIONS BY STATES.—

9 “(1) IN GENERAL.—The Secretary shall estab-
10 lish a process under which a State may propose to
11 provide for certification of entities as meeting the re-
12 quirements of this part to be provider-sponsored or-
13 ganizations.

14 “(2) CONDITIONS FOR APPROVAL.—The Sec-
15 retary may not approve a State program for certifi-
16 cation under paragraph (1) unless the Secretary de-
17 termines that the certification program applies
18 standards and requirements that are identical to the
19 standards and requirements of this part and the ap-
20 plicable provisions for enforcement of such standards
21 and requirements do not result in a lower level or
22 quality of enforcement than that which is otherwise
23 applicable under this title.

24 “(d) NOTICE TO ENROLLEES IN CASE OF DECERTI-
25 FICATION.—If a MedicarePlus organization or product is

1 decertified under this section, the organization shall notify
2 each enrollee with the organization and product under this
3 part of such decertification.

4 “(e) QUALIFIED ASSOCIATIONS.—In the case of
5 MedicarePlus products offered by a MedicarePlus organi-
6 zation that is a qualified association (as defined in section
7 1854(c)(4)(C)) and issued by an organization to which
8 section 1851(b)(1) applies or by a provider-sponsored or-
9 ganization (as defined in section 1854(a)), nothing in this
10 section shall be construed as limiting the authority of
11 States to regulate such products.

12 “CONTRACTS WITH MEDICAREPLUS ORGANIZATIONS

13 “SEC. 1858. (a) IN GENERAL.—The Secretary shall
14 not permit the election under section 1805 of a
15 MedicarePlus product offered by a MedicarePlus organiza-
16 tion under this part, and no payment shall be made under
17 section 1856 to an organization, unless the Secretary has
18 entered into a contract under this section with an organi-
19 zation with respect to the offering of such product. Such
20 a contract with an organization may cover more than one
21 MedicarePlus product. Such contract shall provide that
22 the organization agrees to comply with the applicable re-
23 quirements and standards of this part and the terms and
24 conditions of payment as provided for in this part.

25 “(b) MINIMUM ENROLLMENT REQUIREMENTS.—

1 “(1) IN GENERAL.—Subject to paragraphs (1)
 2 and (2), the Secretary may not enter into a contract
 3 under this section with a MedicarePlus organization
 4 (other than a union sponsor or Taft-Hartley spon-
 5 sor) unless the organization has at least 5,000 indi-
 6 viduals (or 1,500 individuals in the case of an orga-
 7 nization that is a provider-sponsored organization)
 8 who are receiving health benefits through the organi-
 9 zation, except that the standards under section 1856
 10 may permit the organization to have a lesser number
 11 of beneficiaries (but not less than 500 in the case
 12 of an organization that is a provider-sponsored orga-
 13 nization) if the organization primarily serves individ-
 14 uals residing outside of urbanized areas.

15 “(2) EXCEPTION FOR HIGH DEDUCTIBLE/
 16 MEDISAVE PRODUCT.—Paragraph (1) shall not apply
 17 with respect to a contract that relates only to a high
 18 deductible/medisave product.

19 “(3) ALLOWING TRANSITION.—The Secretary
 20 may waive the requirement of paragraph (1) during
 21 the first 3 contract years with respect to an organi-
 22 zation.

23 “(c) CONTRACT PERIOD AND EFFECTIVENESS.—

24 “(1) PERIOD.—Each contract under this sec-
 25 tion shall be for a term of at least one year, as de-

1 terminated by the Secretary, and may be made auto-
2 matically renewable from term to term in the ab-
3 sence of notice by either party of intention to termi-
4 nate at the end of the current term.

5 “(2) TERMINATION AUTHORITY.—In accord-
6 ance with procedures established under subsection
7 (h), the Secretary may at any time terminate any
8 such contract or may impose the intermediate sanc-
9 tions described in an applicable paragraph of sub-
10 section (g) on the MedicarePlus organization if the
11 Secretary determines that the organization—

12 “(A) has failed substantially to carry out
13 the contract;

14 “(B) is carrying out the contract in a man-
15 ner inconsistent with the efficient and effective
16 administration of this part;

17 “(C) is operating in a manner that is not
18 in the best interests of the individuals covered
19 under the contract; or

20 “(D) no longer substantially meets the ap-
21 plicable conditions of this part.

22 “(3) EFFECTIVE DATE OF CONTRACTS.—The
23 effective date of any contract executed pursuant to
24 this section shall be specified in the contract, except
25 that in no case shall a contract under this section

1 which provides for coverage under a high deductible/
2 medisave account be effective before January 1997
3 with respect to such coverage.

4 “(4) PREVIOUS TERMINATIONS.—The Secretary
5 may not enter into a contract with a MedicarePlus
6 organization if a previous contract with that organi-
7 zation under this section was terminated at the re-
8 quest of the organization within the preceding five-
9 year period, except in circumstances which warrant
10 special consideration, as determined by the Sec-
11 retary.

12 “(5) NO CONTRACTING AUTHORITY.—The au-
13 thority vested in the Secretary by this part may be
14 performed without regard to such provisions of law
15 or regulations relating to the making, performance,
16 amendment, or modification of contracts of the
17 United States as the Secretary may determine to be
18 inconsistent with the furtherance of the purpose of
19 this title.

20 “(d) PROTECTIONS AGAINST FRAUD AND BENE-
21 FICIARY PROTECTIONS.—

22 “(1) INSPECTION AND AUDIT.—Each contract
23 under this section shall provide that the Secretary,
24 or any person or organization designated by the Sec-
25 retary—

1 “(A) shall have the right to inspect or oth-
2 erwise evaluate (i) the quality, appropriateness,
3 and timeliness of services performed under the
4 contract and (ii) the facilities of the organiza-
5 tion when there is reasonable evidence of some
6 need for such inspection, and

7 “(B) shall have the right to audit and in-
8 spect any books and records of the
9 MedicarePlus organization that pertain (i) to
10 the ability of the organization to bear the risk
11 of potential financial losses, or (ii) to services
12 performed or determinations of amounts pay-
13 able under the contract.

14 “(2) ENROLLEE NOTICE AT TIME OF TERMI-
15 NATION.—Each contract under this section shall re-
16 quire the organization to provide (and pay for) writ-
17 ten notice in advance of the contract’s termination,
18 as well as a description of alternatives for obtaining
19 benefits under this title, to each individual enrolled
20 with the organization under this part.

21 “(3) DISCLOSURE.—

22 “(A) IN GENERAL.—Each MedicarePlus
23 organization shall, in accordance with regula-
24 tions of the Secretary, report to the Secretary

1 financial information which shall include the
2 following:

3 “(i) Such information as the Sec-
4 retary may require demonstrating that the
5 organization has a fiscally sound operation.

6 “(ii) A copy of the report, if any, filed
7 with the Health Care Financing Adminis-
8 tration containing the information required
9 to be reported under section 1124 by dis-
10 closing entities.

11 “(iii) A description of transactions, as
12 specified by the Secretary, between the or-
13 ganization and a party in interest. Such
14 transactions shall include—

15 “(I) any sale or exchange, or
16 leasing of any property between the
17 organization and a party in interest;

18 “(II) any furnishing for consider-
19 ation of goods, services (including
20 management services), or facilities be-
21 tween the organization and a party in
22 interest, but not including salaries
23 paid to employees for services pro-
24 vided in the normal course of their
25 employment and health services pro-

1 vided to members by hospitals and
2 other providers and by staff, medical
3 group (or groups), individual practice
4 association (or associations), or any
5 combination thereof; and

6 “(III) any lending of money or
7 other extension of credit between an
8 organization and a party in interest.

9 The Secretary may require that information re-
10 ported respecting an organization which con-
11 trols, is controlled by, or is under common con-
12 trol with, another entity be in the form of a
13 consolidated financial statement for the organi-
14 zation and such entity.

15 “(B) PARTY IN INTEREST DEFINED.—For
16 the purposes of this paragraph, the term ‘party
17 in interest’ means—

18 “(i) any director, officer, partner, or
19 employee responsible for management or
20 administration of a MedicarePlus organiza-
21 tion, any person who is directly or indi-
22 rectly the beneficial owner of more than 5
23 percent of the equity of the organization,
24 any person who is the beneficial owner of
25 a mortgage, deed of trust, note, or other

1 interest secured by, and valuing more than
2 5 percent of the organization, and, in the
3 case of a MedicarePlus organization orga-
4 nized as a nonprofit corporation, an incor-
5 porator or member of such corporation
6 under applicable State corporation law;

7 “(ii) any entity in which a person de-
8 scribed in clause (i)—

9 “(I) is an officer or director;

10 “(II) is a partner (if such entity
11 is organized as a partnership);

12 “(III) has directly or indirectly a
13 beneficial interest of more than 5 per-
14 cent of the equity; or

15 “(IV) has a mortgage, deed of
16 trust, note, or other interest valuing
17 more than 5 percent of the assets of
18 such entity;

19 “(iii) any person directly or indirectly
20 controlling, controlled by, or under com-
21 mon control with an organization; and

22 “(iv) any spouse, child, or parent of
23 an individual described in clause (i).

24 “(C) ACCESS TO INFORMATION.—Each
25 MedicarePlus organization shall make the infor-

1 mation reported pursuant to subparagraph (A)
2 available to its enrollees upon reasonable re-
3 quest.

4 “(4) LOAN INFORMATION.—The contract shall
5 require the organization to notify the Secretary of
6 loans and other special financial arrangements which
7 are made between the organization and subcontrac-
8 tors, affiliates, and related parties.

9 “(e) ADDITIONAL CONTRACT TERMS.—The contract
10 shall contain such other terms and conditions not incon-
11 sistent with this part (including requiring the organization
12 to provide the Secretary with such information) as the
13 Secretary may find necessary and appropriate.

14 “(f) INTERMEDIATE SANCTIONS.—

15 “(1) IN GENERAL.—If the Secretary determines
16 that a MedicarePlus organization with a contract
17 under this section—

18 “(A) fails substantially to provide medi-
19 cally necessary items and services that are re-
20 quired (under law or under the contract) to be
21 provided to an individual covered under the con-
22 tract, if the failure has adversely affected (or
23 has substantial likelihood of adversely affecting)
24 the individual;

1 “(B) imposes premiums on individuals en-
2 rolled under this part in excess of the premiums
3 permitted;

4 “(C) acts to expel or to refuse to re-enroll
5 an individual in violation of the provisions of
6 this part;

7 “(D) engages in any practice that would
8 reasonably be expected to have the effect of de-
9 nying or discouraging enrollment (except as
10 permitted by this part) by eligible individuals
11 with the organization whose medical condition
12 or history indicates a need for substantial fu-
13 ture medical services;

14 “(E) misrepresents or falsifies information
15 that is furnished—

16 “(i) to the Secretary under this part,
17 or

18 “(ii) to an individual or to any other
19 entity under this part;

20 “(F) fails to comply with the requirements
21 of section 1852(f)(3); or

22 “(G) employs or contracts with any indi-
23 vidual or entity that is excluded from participa-
24 tion under this title under section 1128 or
25 1128A for the provision of health care, utiliza-

1 tion review, medical social work, or administra-
 2 tive services or employs or contracts with any
 3 entity for the provision (directly or indirectly)
 4 through such an excluded individual or entity of
 5 such services;

6 the Secretary may provide, in addition to any other
 7 remedies authorized by law, for any of the remedies
 8 described in paragraph (2).

9 “(2) REMEDIES.—The remedies described in
 10 this paragraph are—

11 “(A) civil money penalties of not more
 12 than \$25,000 for each determination under
 13 paragraph (1) or, with respect to a determina-
 14 tion under subparagraph (D) or (E)(i) of such
 15 paragraph, of not more than \$100,000 for each
 16 such determination, plus, with respect to a de-
 17 termination under paragraph (1)(B), double the
 18 excess amount charged in violation of such
 19 paragraph (and the excess amount charged
 20 shall be deducted from the penalty and returned
 21 to the individual concerned), and plus, with re-
 22 spect to a determination under paragraph
 23 (1)(D), \$15,000 for each individual not enrolled
 24 as a result of the practice involved,

1 “(B) suspension of enrollment of individ-
2 uals under this part after the date the Sec-
3 retary notifies the organization of a determina-
4 tion under paragraph (1) and until the Sec-
5 retary is satisfied that the basis for such deter-
6 mination has been corrected and is not likely to
7 recur, or

8 “(C) suspension of payment to the organi-
9 zation under this part for individuals enrolled
10 after the date the Secretary notifies the organi-
11 zation of a determination under paragraph (1)
12 and until the Secretary is satisfied that the
13 basis for such determination has been corrected
14 and is not likely to recur.

15 “(3) OTHER INTERMEDIATE SANCTIONS.—In
16 the case of a MedicarePlus organization for which
17 the Secretary makes a determination under sub-
18 section (c)(2) the basis of which is not described in
19 paragraph (1), the Secretary may apply the follow-
20 ing intermediate sanctions:

21 “(A) civil money penalties of not more
22 than \$25,000 for each determination under
23 subsection (c)(2) if the deficiency that is the
24 basis of the determination has directly adversely
25 affected (or has the substantial likelihood of ad-

1 versely affecting) an individual covered under
2 the organization’s contract;

3 “(B) civil money penalties of not more
4 than \$10,000 for each week beginning after the
5 initiation of procedures by the Secretary under
6 subsection (h) during which the deficiency that
7 is the basis of a determination under subsection
8 (c)(2) exists; and

9 “(C) suspension of enrollment of individ-
10 uals under this part after the date the Sec-
11 retary notifies the organization of a determina-
12 tion under subsection (c)(2) and until the Sec-
13 retary is satisfied that the deficiency that is the
14 basis for the determination has been corrected
15 and is not likely to recur.

16 “(4) PROCEDURES FOR IMPOSING SANC-
17 TIONS.—The provisions of section 1128A (other
18 than subsections (a) and (b)) shall apply to a civil
19 money penalty under paragraph (1) or (2) in the
20 same manner as they apply to a civil money penalty
21 or proceeding under section 1128A(a).

22 “(g) PROCEDURES FOR IMPOSING SANCTIONS.—The
23 Secretary may terminate a contract with a MedicarePlus
24 organization under this section or may impose the inter-
25 mediate sanctions described in subsection (f) on the orga-

1 nization in accordance with formal investigation and com-
2 pliance procedures established by the Secretary under
3 which—

4 “(1) the Secretary provides the organization
5 with the opportunity to develop and implement a
6 corrective action plan to correct the deficiencies that
7 were the basis of the Secretary’s determination
8 under subsection (c)(2);

9 “(2) the Secretary shall impose more severe
10 sanctions on organizations that have a history of de-
11 ficiencies or that have not taken steps to correct de-
12 ficiencies the Secretary has brought to their atten-
13 tion;

14 “(3) there are no unreasonable or unnecessary
15 delays between the finding of a deficiency and the
16 imposition of sanctions; and

17 “(4) the Secretary provides the organization
18 with reasonable notice and opportunity for hearing
19 (including the right to appeal an initial decision) be-
20 fore imposing any sanction or terminating the con-
21 tract.”.

22 (b) CONFORMING REFERENCES TO PREVIOUS PART
23 C.—Any reference in law (in effect before the date of the
24 enactment of this Act) to part C of title XVIII of the So-

1 cial Security Act is deemed a reference to part D of such
2 title (as in effect after such date).

3 (c) USE OF INTERIM, FINAL REGULATIONS.—In
4 order to carry out the amendment made by subsection (a)
5 in a timely manner, the Secretary of Health and Human
6 Services may promulgate regulations that take effect on
7 an interim basis, after notice and pending opportunity for
8 public comment.

9 (d) ADVANCE DIRECTIVES.—Section 1866(f) (42
10 U.S.C. 1395cc(f)) is amended—

11 (1) in paragraph (1)—

12 (A) by inserting “1853(g),” after
13 “1833(s),”, and

14 (B) by inserting “, MedicarePlus organiza-
15 tion,” after “provider of services”, and

16 (2) by adding at the end the following new
17 paragraph:

18 “(4) Nothing in this subsection shall be construed to
19 require the provision of information regarding assisted
20 suicide, euthanasia, or mercy killing.”.

21 (e) CONFORMING AMENDMENT.—Section
22 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended
23 by inserting before the semicolon at the end the following:
24 “and in the case of hospitals to accept as payment in full
25 for inpatient hospital services that are emergency services

1 (as defined in section 1853(b)(4)) that are covered under
 2 this title and are furnished to any individual enrolled
 3 under part C with a MedicarePlus organization which does
 4 not have a contract establishing payment amounts for
 5 services furnished to members of the organization the
 6 amounts that would be made as a payment in full under
 7 this title if the individuals were not so enrolled”.

8 **SEC. 15003. DUPLICATION AND COORDINATION OF MEDI-**
 9 **CARE-RELATED PRODUCTS.**

10 (a) TREATMENT OF CERTAIN HEALTH INSURANCE
 11 POLICIES AS NONDUPLICATIVE.—

12 (1) IN GENERAL.—Effective as if included in
 13 the enactment of section 4354 of the Omnibus
 14 Budget Reconciliation Act of 1990, section
 15 1882(d)(3)(A) (42 U.S.C. 1395ss(d)(3)(A)) is
 16 amended—

17 (A) by amending clause (i) to read as fol-
 18 lows:

19 “(i) It is unlawful for a person to sell or issue to an
 20 individual entitled to benefits under part A or enrolled
 21 under part B of this title or electing a MedicarePlus prod-
 22 uct under section 1805—

23 “(I) a health insurance policy (other than a
 24 medicare supplemental policy) with knowledge that
 25 the policy duplicates health benefits to which the in-

1 dividual is otherwise entitled under this title or title
2 XIX,

3 “(II) in the case of an individual not electing a
4 MedicarePlus product, a medicare supplemental pol-
5 icy with knowledge that the individual is entitled to
6 benefits under another medicare supplemental policy,
7 or

8 “(III) in the case of an individual electing a
9 MedicarePlus product, a medicare supplemental pol-
10 icy with knowledge that the policy duplicates health
11 benefits to which the individual is otherwise entitled
12 under this title or under another medicare supple-
13 mental policy.”;

14 (B) in clause (iii), by striking “clause (i)”
15 and inserting “clause (i)(II)”; and

16 (C) by adding at the end the following new
17 clauses:

18 “(iv) For purposes of this subparagraph a health in-
19 surance policy shall be considered to ‘duplicate’ benefits
20 under this title only when, under its terms, the policy pro-
21 vides specific reimbursement for identical items and serv-
22 ices to the extent paid for under this title, and a health
23 insurance policy providing for benefits which are payable
24 to or on behalf of an individual without regard to other

1 health benefit coverage of such individual is not considered
2 to ‘duplicate’ any health benefits under this title.

3 “(v) For purposes of this subparagraph, a health in-
4 surance policy (or a rider to an insurance contract which
5 is not a health insurance policy), including a policy (such
6 as a long-term care insurance contract described in section
7 7702B(b) of the Internal Revenue Code of 1986, as added
8 by the Contract with America Tax Relief Act of 1995
9 (H.R. 1215)) providing benefits for long-term care, nurs-
10 ing home care, home health care, or community-based
11 care, that coordinates against or excludes items and serv-
12 ices available or paid for under this title and (for policies
13 sold or issued after January 1, 1996) that discloses such
14 coordination or exclusion in the policy’s outline of cov-
15 erage, is not considered to ‘duplicate’ health benefits
16 under this title. For purposes of this clause, the terms ‘co-
17 ordinates’ and ‘coordination’ mean, with respect to a pol-
18 icy in relation to health benefits under this title, that the
19 policy under its terms is secondary to, or excludes from
20 payment, items and services to the extent available or paid
21 for under this title.

22 “(vi) Notwithstanding any other provision of law, no
23 criminal or civil penalty may be imposed at any time under
24 this subparagraph and no legal action may be brought or
25 continued at any time in any Federal or State court if

1 the penalty or action is based on an act or omission that
 2 occurred after November 5, 1991, and before the date of
 3 the enactment of this clause, and relates to the sale, issu-
 4 ance, or renewal of any health insurance policy during
 5 such period, if such policy meets the requirements of
 6 clause (iv) or (v).

7 “(vii) A State may not impose, with respect to the
 8 sale or issuance of a policy (or rider) that meets the re-
 9 quirements of this title pursuant to clause (iv) or (v) to
 10 an individual entitled to benefits under part A or enrolled
 11 under part B or enrolled under a MedicarePlus product
 12 under part C, any requirement based on the premise that
 13 such a policy or rider duplicates health benefits to which
 14 the individual is otherwise entitled under this title.”.

15 (2) CONFORMING AMENDMENTS.—Section
 16 1882(d)(3) (42 U.S.C. 1395ss(d)(3)) is amended—

17 (A) in subparagraph (B), by inserting
 18 “(including any MedicarePlus product)” after
 19 “health insurance policies”;

20 (B) in subparagraph (C)—

21 (i) by striking “with respect to (i)”
 22 and inserting “with respect to”, and

23 (ii) by striking “, (ii) the sale” and all
 24 that follows up to the period at the end;
 25 and

1 (C) by striking subparagraph (D).

2 (3) MEDICAREPLUS PRODUCTS NOT TREATED
3 AS MEDICARE SUPPLEMENTARY POLICIES.—Section
4 1882(g) (42 U.S.C. 1395ss(g)) is amended by in-
5 serting “a MedicarePlus product or” after “and does
6 not include”

7 (4) REPORT ON DUPLICATION AND COORDINA-
8 TION OF HEALTH INSURANCE POLICIES THAT ARE
9 NOT MEDICARE SUPPLEMENTAL POLICIES.—Not
10 later than 3 years after the date of the enactment
11 of this Act, the Secretary of Health and Human
12 Services shall prepare and submit to Congress a re-
13 port on the advisability and feasibility of restricting
14 the sale to medicare beneficiaries of health insurance
15 policies that duplicate (within the meaning of section
16 1882(d)(3)(A) of the Social Security Act) other
17 health insurance policies that such a beneficiary may
18 have. In preparing such report, the Secretary shall
19 seek the advice of the National Association of Insur-
20 ance Commissioners and shall take into account the
21 standards established under section 1807 of the So-
22 cial Security Act for the electronic coordination of
23 benefits.

24 (b) ADDITIONAL RULES RELATING TO INDIVIDUALS
25 ENROLLED IN MEDICAREPLUS PRODUCTS.—Section

1 1882 (42 U.S.C. 1395ss) is further amended by adding
2 at the end the following new subsection:

3 “(u)(1) Notwithstanding the previous provisions of
4 this section, the following provisions shall not apply to a
5 health insurance policy (other than a medicare supple-
6 mental policy) provided to an individual who has elected
7 the MedicarePlus option under section 1805:

8 “(A) Subsections (o)(1), (o)(2), (p)(1)(A)(i),
9 (p)(2), (p)(3), (p)(8), and (p)(9) (insofar as they re-
10 late to limitations on benefits or groups of benefits
11 that may be offered).

12 “(B) Subsection (r) (relating to loss-ratios).

13 “(2)(A) It is unlawful for a person to sell or issue
14 a policy described in subparagraph (B) to an individual
15 with knowledge that the individual has in effect under sec-
16 tion 1805 an election of a high deductible/medisave prod-
17 uct.

18 “(B) A policy described in this subparagraph is a
19 health insurance policy that provides for coverage of ex-
20 penses that are otherwise required to be counted toward
21 meeting the annual deductible amount provided under the
22 high deductible/medisave product.”.

23 **SEC. 15004. TRANSITIONAL RULES FOR CURRENT MEDI-**
24 **CARE HMO PROGRAM.**

25 (a) TRANSITION FROM CURRENT CONTRACTS.—

1 (1) LIMITATION ON NEW CONTRACTS.—

2 (A) NO NEW RISK-SHARING CONTRACTS
 3 AFTER NEW STANDARDS ESTABLISHED.—The
 4 Secretary of Health and Human Services (in
 5 this section referred to as the “Secretary”)
 6 shall not enter into any risk-sharing contract
 7 under section 1876 of the Social Security Act
 8 with an eligible organization for any contract
 9 year beginning on or after the date standards
 10 for MedicarePlus organizations and products
 11 are first established under section 1856(a) of
 12 such Act with respect to MedicarePlus organi-
 13 zations that are insurers or health maintenance
 14 organizations unless such a contract had been
 15 in effect under section 1876 of such Act for the
 16 organization for the previous contract year.

17 (B) NO NEW COST REIMBURSEMENT CON-
 18 TRACTS.—The Secretary shall not enter into
 19 any cost reimbursement contract under section
 20 1876 of the Social Security Act beginning for
 21 any contract year beginning on or after the
 22 date of the enactment of this Act.

23 (2) TERMINATION OF CURRENT CONTRACTS.—

24 (A) RISK-SHARING CONTRACTS.—Notwith-
 25 standing any other provision of law, the Sec-

1 retary shall not extend or continue any risk-
2 sharing contract with an eligible organization
3 under section 1876 of the Social Security Act
4 (for which a contract was entered into consist-
5 ent with paragraph (1)(A)) for any contract
6 year beginning on or after 1 year after the date
7 standards described in paragraph (1)(A) are es-
8 tablished.

9 (B) COST REIMBURSEMENT CONTRACTS.—

10 The Secretary shall not extend or continue any
11 reasonable cost reimbursement contract with an
12 eligible organization under section 1876 of the
13 Social Security Act for any contract year begin-
14 ning on or after January 1, 1998.

15 (b) CONFORMING PAYMENT RATES.—

16 (1) RISK-SHARING CONTRACTS.—Notwithstand-
17 ing any other provision of law, the Secretary shall
18 provide that payment amounts under risk-sharing
19 contracts under section 1876(a) of the Social Secu-
20 rity Act for months in a year (beginning with Janu-
21 ary 1996) shall be computed—

22 (A) with respect to individuals entitled to
23 benefits under both parts A and B of title
24 XVIII of such Act, by substituting payment
25 rates under section 1855(a) of such Act for the

1 payment rates otherwise established under sec-
2 tion 1876(a) of such Act, and

3 (B) with respect to individuals only enti-
4 tled to benefits under part B of such title, by
5 substituting an appropriate proportion of such
6 rates (reflecting the relative proportion of pay-
7 ments under such title attributable to such
8 part) for the payment rates otherwise estab-
9 lished under section 1876(a) of such Act.

10 For purposes of carrying out this paragraph for pay-
11 ment for months in 1996, the Secretary shall com-
12 pute, announce, and apply the payment rates under
13 section 1855(a) of such Act (notwithstanding any
14 deadlines specified in such section) in as timely a
15 manner as possible and may (to the extent nec-
16 essary) provide for retroactive adjustment in pay-
17 ments made not in accordance with such rates.

18 (2) COST CONTRACTS.—Notwithstanding any
19 other provision of law, the Secretary shall provide
20 that payment amounts under cost reimbursement
21 contracts under section 1876(a) of the Social Secu-
22 rity Act shall take into account adjustments in pay-
23 ment amounts made in parts A and B of title XVIII
24 of such Act pursuant to the amendments made by
25 this title.

1 (c) ELIMINATION OF 50:50 RULE.—

2 (1) IN GENERAL.—Section 1876 (42 U.S.C.
3 1395mm) is amended by striking subsection (f).

4 (2) CONFORMING AMENDMENTS.—Section 1876
5 is further amended—

6 (A) in subsection (c)(3)(A)(i), by striking
7 “would result in failure to meet the require-
8 ments of subsection (f) or”, and

9 (B) in subsection (i)(1)(C), by striking
10 “(e), and (f)” and inserting “and (e)”.

11 (3) EFFECTIVE DATE.—The amendments made
12 by this section shall apply to contract years begin-
13 ning on or after January 1, 1996.

14 **PART 2—SPECIAL RULES FOR MEDICAREPLUS**

15 **MEDICAL SAVINGS ACCOUNTS**

16 **SEC. 15011. MEDICAREPLUS MSA’S.**

17 (a) IN GENERAL.—Part III of subchapter B of chap-
18 ter 1 of the Internal Revenue Code of 1986 (relating to
19 amounts specifically excluded from gross income) is
20 amended by redesignating section 137 as section 138 and
21 by inserting after section 136 the following new section:

22 **“SEC. 137. MEDICAREPLUS MSA’S.**

23 “(a) EXCLUSION.—Gross income shall not include
24 any payment to the MedicarePlus MSA of an individual

1 by the Secretary of Health and Human Services under
2 section 1855(f)(1)(B) of the Social Security Act.

3 “(b) **MEDICAREPLUS MSA.**—For purposes of this
4 section—

5 “(1) **MEDICAREPLUS MSA.**—The term
6 ‘MedicarePlus MSA’ means a trust created or orga-
7 nized in the United States exclusively for the pur-
8 pose of paying the qualified medical expenses of the
9 account holder, but only if the written governing in-
10 strument creating the trust meets the following re-
11 quirements:

12 “(A) Except in the case of a trustee-to-
13 trustee transfer described in subsection (d)(4),
14 no contribution will be accepted unless it is
15 made by the Secretary of Health and Human
16 Services under section 1855(f)(1)(B) of the So-
17 cial Security Act.

18 “(B) The trustee is a bank (as defined in
19 section 408(n)), an insurance company (as de-
20 fined in section 816), or another person who
21 demonstrates to the satisfaction of the Sec-
22 retary that the manner in which such person
23 will administer the trust will be consistent with
24 the requirements of this section.

1 “(C) No part of the trust assets will be in-
2 vested in life insurance contracts.

3 “(D) The assets of the trust will not be
4 commingled with other property except in a
5 common trust fund or common investment
6 fund.

7 “(E) The interest of an individual in the
8 balance in his account is nonforfeitable.

9 “(F) Trustee-to-trustee transfers described
10 in subsection (d)(4) may be made to and from
11 the trust.

12 “(2) QUALIFIED MEDICAL EXPENSES.—

13 “(A) IN GENERAL.—The term ‘qualified
14 medical expenses’ means, with respect to an ac-
15 count holder, amounts paid by such holder—

16 “(i) for medical care (as defined in
17 section 213(d)) for the account holder, but
18 only to the extent such amounts are not
19 compensated for by insurance or otherwise,
20 or

21 “(ii) for long-term care insurance for
22 the account holder.

23 “(B) HEALTH INSURANCE MAY NOT BE
24 PURCHASED FROM ACCOUNT.—Subparagraph

1 (A)(i) shall not apply to any payment for insur-
2 ance.

3 “(3) ACCOUNT HOLDER.—The term ‘account
4 holder’ means the individual on whose behalf the
5 MedicarePlus MSA is maintained.

6 “(4) CERTAIN RULES TO APPLY.—Rules similar
7 to the rules of subsections (g) and (h) of section 408
8 shall apply for purposes of this section.

9 “(c) TAX TREATMENT OF ACCOUNTS.—

10 “(1) IN GENERAL.—A MedicarePlus MSA is ex-
11 empt from taxation under this subtitle unless such
12 MSA has ceased to be a MedicarePlus MSA by rea-
13 son of paragraph (2). Notwithstanding the preceding
14 sentence, any such MSA is subject to the taxes im-
15 posed by section 511 (relating to imposition of tax
16 on unrelated business income of charitable, etc. or-
17 ganizations).

18 “(2) ACCOUNT ASSETS TREATED AS DISTRIB-
19 UTED IN THE CASE OF PROHIBITED TRANSACTIONS
20 OR ACCOUNT PLEDGED AS SECURITY FOR LOAN.—
21 Rules similar to the rules of paragraphs (2) and (4)
22 of section 408(e) shall apply to MedicarePlus
23 MSA’s, and any amount treated as distributed under
24 such rules shall be treated as not used to pay quali-
25 fied medical expenses.

1 “(d) TAX TREATMENT OF DISTRIBUTIONS.—

2 “(1) INCLUSION OF AMOUNTS NOT USED FOR
3 QUALIFIED MEDICAL EXPENSES.—No amount shall
4 be included in the gross income of the account hold-
5 er by reason of a payment or distribution from a
6 MedicarePlus MSA which is used exclusively to pay
7 the qualified medical expenses of the account holder.
8 Any amount paid or distributed from a
9 MedicarePlus MSA which is not so used shall be in-
10 cluded in the gross income of such holder.

11 “(2) PENALTY FOR DISTRIBUTIONS NOT USED
12 FOR QUALIFIED MEDICAL EXPENSES IF MINIMUM
13 BALANCE NOT MAINTAINED.—

14 “(A) IN GENERAL.—The tax imposed by
15 this chapter for any taxable year in which there
16 is a payment or distribution from a
17 MedicarePlus MSA which is not used exclu-
18 sively to pay the qualified medical expenses of
19 the account holder shall be increased by 50 per-
20 cent of the excess (if any) of—

21 “(i) the amount of such payment or
22 distribution, over

23 “(ii) the excess (if any) of—

24 “(I) the fair market value of the
25 assets in the MedicarePlus MSA as of

1 the close of the calendar year preced-
2 ing the calendar year in which the
3 taxable year begins, over

4 “(II) an amount equal to 60 per-
5 cent of the deductible under the high
6 deductible/medisave product covering
7 the account holder as of January 1 of
8 the calendar year in which the taxable
9 year begins.

10 “(B) EXCEPTIONS.—Subparagraph (A)
11 shall not apply if the payment or distribution is
12 made on or after the date the account holder—

13 “(i) becomes disabled within the
14 meaning of section 72(m)(7), or

15 “(ii) dies.

16 “(C) SPECIAL RULES.—For purposes of
17 subparagraph (A)—

18 “(i) all MedicarePlus MSA’s of the ac-
19 count holder shall be treated as 1 account,

20 “(ii) all payments and distributions
21 not used exclusively to pay the qualified
22 medical expenses of the account holder
23 during any taxable year shall be treated as
24 1 distribution, and

1 “(iii) any distribution of property
2 shall be taken into account at its fair mar-
3 ket value on the date of the distribution.

4 “(3) WITHDRAWAL OF ERRONEOUS CONTRIBU-
5 TIONS.—Paragraphs (1) and (2) shall not apply to
6 any payment or distribution from a MedicarePlus
7 MSA to the Secretary of Health and Human Serv-
8 ices of an erroneous contribution to such MSA and
9 of the net income attributable to such contribution.

10 “(4) TRUSTEE-TO-TRUSTEE TRANSFERS.—
11 Paragraphs (1) and (2) shall not apply to any trust-
12 ee-to-trustee transfer from a MedicarePlus MSA of
13 an account holder to another MedicarePlus MSA of
14 such account holder.

15 “(5) COORDINATION WITH MEDICAL EXPENSE
16 DEDUCTION.—For purposes of section 213, any pay-
17 ment or distribution out of a MedicarePlus MSA for
18 qualified medical expenses shall not be treated as an
19 expense paid for medical care.

20 “(e) TREATMENT OF ACCOUNT AFTER DEATH OF
21 ACCOUNT HOLDER.—

22 “(1) TREATMENT IF DESIGNATED BENEFICIARY
23 IS SPOUSE.—

24 “(A) IN GENERAL.—In the case of an ac-
25 count holder’s interest in a MedicarePlus MSA

1 which is payable to (or for the benefit of) such
 2 holder’s spouse upon the death of such holder,
 3 such MedicarePlus MSA shall be treated as a
 4 MedicarePlus MSA of such spouse as of the
 5 date of such death.

6 “(B) SPECIAL RULES IF SPOUSE NOT MED-
 7 ICARE ELIGIBLE.—If, as of the date of such
 8 death, such spouse is not entitled to benefits
 9 under title XVIII of the Social Security Act,
 10 then after the date of such death—

11 “(i) the Secretary of Health and
 12 Human Services may not make any pay-
 13 ments to such MedicarePlus MSA, other
 14 than payments attributable to periods be-
 15 fore such date,

16 “(ii) in applying subsection (b)(2)
 17 with respect to such MedicarePlus MSA,
 18 references to the account holder shall be
 19 treated as including references to any de-
 20 pendent (as defined in section 152) of such
 21 spouse and any subsequent spouse of such
 22 spouse, and

23 “(iii) in lieu of applying subsection
 24 (d)(2), the rules of section 220(f)(2) shall
 25 apply.

1 “(2) TREATMENT IF DESIGNATED BENEFICIARY
2 IS NOT SPOUSE.—In the case of an account holder’s
3 interest in a MedicarePlus MSA which is payable to
4 (or for the benefit of) any person other than such
5 holder’s spouse upon the death of such holder—

6 “(A) such account shall cease to be a
7 MedicarePlus MSA as of the date of death, and

8 “(B) an amount equal to the fair market
9 value of the assets in such account on such date
10 shall be includible—

11 “(i) if such person is not the estate of
12 such holder, in such person’s gross income
13 for the taxable year which includes such
14 date, or

15 “(ii) if such person is the estate of
16 such holder, in such holder’s gross income
17 for last taxable year of such holder.

18 “(f) REPORTS.—

19 “(1) IN GENERAL.—The trustee of a
20 MedicarePlus MSA shall make such reports regard-
21 ing such account to the Secretary and to the account
22 holder with respect to—

23 “(A) the fair market value of the assets in
24 such MedicarePlus MSA as of the close of each
25 calendar year, and

1 “(B) contributions, distributions, and other
2 matters,
3 as the Secretary may require by regulations.

4 “(2) TIME AND MANNER OF REPORTS.—The re-
5 ports required by this subsection—

6 “(A) shall be filed at such time and in
7 such manner as the Secretary prescribes in
8 such regulations, and

9 “(B) shall be furnished to the account
10 holder—

11 “(i) not later than January 31 of the
12 calendar year following the calendar year
13 to which such reports relate, and

14 “(ii) in such manner as the Secretary
15 prescribes in such regulations.”

16 (b) EXCLUSION OF MEDICAREPLUS MSA’S FROM
17 ESTATE TAX.—Part IV of subchapter A of chapter 11 of
18 such Code is amended by adding at the end the following
19 new section:

20 **“SEC. 2057. MEDICAREPLUS MSA’S.**

21 “For purposes of the tax imposed by section 2001,
22 the value of the taxable estate shall be determined by de-
23 ducting from the value of the gross estate an amount
24 equal to the value of any MedicarePlus MSA (as defined
25 in section 137(b)) included in the gross estate.”

1 (c) TAX ON PROHIBITED TRANSACTIONS.—

2 (1) Section 4975 of such Code (relating to tax
3 on prohibited transactions) is amended by adding at
4 the end of subsection (c) the following new para-
5 graph:

6 “(4) SPECIAL RULE FOR MEDICAREPLUS
7 MSA’S.—An individual for whose benefit a
8 MedicarePlus MSA (within the meaning of section
9 137(b)) is established shall be exempt from the tax
10 imposed by this section with respect to any trans-
11 action concerning such account (which would other-
12 wise be taxable under this section) if, with respect
13 to such transaction, the account ceases to be a
14 MedicarePlus MSA by reason of the application of
15 section 137(c)(2) to such account.”

16 (2) Paragraph (1) of section 4975(e) of such
17 Code is amended to read as follows:

18 “(1) PLAN.—For purposes of this section, the
19 term ‘plan’ means—

20 “(A) a trust described in section 401(a)
21 which forms a part of a plan, or a plan de-
22 scribed in section 403(a), which trust or plan is
23 exempt from tax under section 501(a),

24 “(B) an individual retirement account de-
25 scribed in section 408(a),

1 “(C) an individual retirement annuity de-
2 scribed in section 408(b),

3 “(D) a medical savings account described
4 in section 220(d),

5 “(E) a MedicarePlus MSA described in
6 section 137(b), or

7 “(F) a trust, plan, account, or annuity
8 which, at any time, has been determined by the
9 Secretary to be described in any preceding sub-
10 paragraph of this paragraph.”

11 (d) FAILURE TO PROVIDE REPORTS ON
12 MEDICAREPLUS MSA’S.—

13 (1) Subsection (a) of section 6693 of such Code
14 (relating to failure to provide reports on individual
15 retirement accounts or annuities) is amended to read
16 as follows:

17 “(a) REPORTS.—

18 “(1) IN GENERAL.—If a person required to file
19 a report under a provision referred to in paragraph
20 (2) fails to file such report at the time and in the
21 manner required by such provision, such person
22 shall pay a penalty of \$50 for each failure unless it
23 is shown that such failure is due to reasonable
24 cause.

1 “(2) PROVISIONS.—The provisions referred to
2 in this paragraph are—

3 “(A) subsections (i) and (l) of section 408
4 (relating to individual retirement plans),

5 “(B) section 220(h) (relating to medical
6 savings accounts), and

7 “(C) section 137(f) (relating to
8 MedicarePlus MSA’s).”

9 (2) The section heading for section 6693 of
10 such Code is amended to read as follows:

11 **“SEC. 6693. FAILURE TO FILE REPORTS ON INDIVIDUAL RE-**
12 **TIREMENT PLANS AND CERTAIN OTHER TAX-**
13 **FAVORED ACCOUNTS; PENALTIES RELATING**
14 **TO DESIGNATED NONDEDUCTIBLE CON-**
15 **TRIBUTIONS.”**

16 (e) CLERICAL AMENDMENTS.—

17 (1) The table of sections for part III of sub-
18 chapter B of chapter 1 of such Code is amended by
19 striking the last item and inserting the following:

“Sec. 137. MedicarePlus MSA’s.

“Sec. 138. Cross references to other Acts.”

20 (2) The table of sections for part 1 of sub-
21 chapter B of chapter 68 of such Code is amended

1 by striking the item relating to section 6693 and in-
2 serting the following new item:

“Sec. 6693. Failure to file reports on individual retirement plans and certain other tax-favored accounts; penalties relating to designated nondeductible contributions.”

3 (3) The table of sections for part IV of sub-
4 chapter A of chapter 11 of such Code is amended by
5 adding at the end the following new item:

“Sec. 2057. MedicarePlus MSA’s.”

6 (f) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to taxable years beginning after
8 December 31, 1996.

9 **SEC. 15012. CERTAIN REBATES EXCLUDED FROM GROSS**
10 **INCOME.**

11 (a) IN GENERAL.—Section 105 of the Internal Reve-
12 nue Code of 1986 (relating to amounts received under ac-
13 cident and health plans) is amended by adding at the end
14 the following new subsection:

15 “(j) CERTAIN REBATES UNDER SOCIAL SECURITY
16 ACT.—Gross income does not include any rebate received
17 under section 1852(e)(1)(A) of the Social Security Act
18 during the taxable year.”

19 (b) EFFECTIVE DATE.—The amendment made by
20 subsection (a) shall apply to amounts received after the
21 date of the enactment of this Act.

1 **PART 3—SPECIAL ANTITRUST RULE FOR**
 2 **PROVIDER SERVICE NETWORKS**

3 **SEC. 15021. APPLICATION OF ANTITRUST RULE OF REASON**
 4 **TO PROVIDER SERVICE NETWORKS.**

5 (a) RULE OF REASON STANDARD.—In any action
 6 under the antitrust laws, or under any State law similar
 7 to the antitrust laws—

8 (1) the conduct of a provider service network in
 9 negotiating, making, or performing a contract (in-
 10 cluding the establishment and modification of a fee
 11 schedule and the development of a panel of physi-
 12 cians), to the extent such contract is for the purpose
 13 of providing health care services to individuals under
 14 the terms of a MedicarePlus PSO product, and

15 (2) the conduct of any member of such network
 16 for the purpose of providing such health care serv-
 17 ices under such contract to such extent,

18 shall not be deemed illegal per se. Such conduct shall be
 19 judged on the basis of its reasonableness, taking into ac-
 20 count all relevant factors affecting competition, including
 21 the effects on competition in properly defined markets.

22 (b) DEFINITIONS.—For purposes of subsection (a):

23 (1) ANTITRUST LAWS.—The term “antitrust
 24 laws” has the meaning given it in subsection (a) of
 25 the first section of the Clayton Act (15 U.S.C. 12),
 26 except that such term includes section 5 of the Fed-

1 eral Trade Commission Act (15 U.S.C. 45) to the
2 extent that such section 5 applies to unfair methods
3 of competition.

4 (2) HEALTH CARE PROVIDER.—The term
5 “health care provider” means any individual or en-
6 tity that is engaged in the delivery of health care
7 services in a State and that is required by State law
8 or regulation to be licensed or certified by the State
9 to engage in the delivery of such services in the
10 State.

11 (3) HEALTH CARE SERVICE.—The term “health
12 care service” means any service for which payment
13 may be made under a MedicarePlus PSO product in-
14 cluding services related to the delivery or adminis-
15 tration of such service.

16 (4) MEDICAREPLUS PROGRAM.—The term
17 “MedicarePlus program” means the program under
18 part C of title XVIII of the Social Security Act.

19 (5) MEDICAREPLUS PSO PRODUCT.—The term
20 “MedicarePlus PSO product” means a MedicarePlus
21 product offered by a provider-sponsored organization
22 under part C of title XVIII of the Social Security
23 Act.

1 (6) PROVIDER SERVICE NETWORK.—The term
2 “provider service network” means an organization
3 that—

4 (A) is organized by, operated by, and com-
5 posed of members who are health care providers
6 and for purposes that include providing health
7 care services,

8 (B) is funded in part by capital contribu-
9 tions made by the members of such organiza-
10 tion,

11 (C) with respect to each contract made by
12 such organization for the purpose of providing
13 a type of health care service to individuals
14 under the terms of a MedicarePlus PSO prod-
15 uct—

16 (i) requires all members of such orga-
17 nization who engage in providing such type
18 of health care service to agree to provide
19 health care services of such type under
20 such contract,

21 (ii) receives the compensation paid for
22 the health care services of such type pro-
23 vided under such contract by such mem-
24 bers, and

1 (iii) provides for the distribution of
2 such compensation,

3 (D) has established, consistent with the re-
4 quirements of the MedicarePlus program for
5 provider-sponsored organizations, a program to
6 review, pursuant to written guidelines, the qual-
7 ity, efficiency, and appropriateness of treatment
8 methods and setting of services for all health
9 care providers and all patients participating in
10 such product, along with internal procedures to
11 correct identified deficiencies relating to such
12 methods and such services,

13 (E) has established, consistent with the re-
14 quirements of the MedicarePlus program for
15 provider-sponsored organizations, a program to
16 monitor and control utilization of health care
17 services provided under such product, for the
18 purpose of improving efficient, appropriate care
19 and eliminating the provision of unnecessary
20 health care services,

21 (F) has established a management pro-
22 gram to coordinate the delivery of health care
23 services for all health care providers and all pa-
24 tients participating in such product, for the

1 purpose of achieving efficiencies and enhancing
 2 the quality of health care services provided, and
 3 (G) has established, consistent with the re-
 4 quirements of the MedicarePlus program for
 5 provider-sponsored organizations, a grievance
 6 and appeal process for such organization de-
 7 signed to review and promptly resolve bene-
 8 ficiary or patient grievances and complaints.

9 Such term may include a provider-sponsored organi-
 10 zation.

11 (7) PROVIDER-SPONSORED ORGANIZATION.—
 12 The term “provider-sponsored organization” means
 13 a MedicarePlus organization under the MedicarePlus
 14 program that is a provider-sponsored organization
 15 (as defined in section ____ of the Social Security
 16 Act).

17 (8) STATE.—The term “State” has the mean-
 18 ing given it in section 4G(2) of the Clayton Act (15
 19 U.S.C. 15g(2)).

20 (c) ISSUANCE OF GUIDELINES.—Not later than 120
 21 days after the date of the enactment of this Act, the Attor-
 22 ney General and the Federal Trade Commission shall
 23 issue jointly guidelines specifying the enforcement policies
 24 and analytical principles that will be applied by the De-

1 partment of Justice and the Commission with respect to
2 the operation of subsection (a).

3 **PART 4—COMMISSIONS**

4 **SEC. 15031. MEDICARE PAYMENT REVIEW COMMISSION.**

5 (a) IN GENERAL.—Title XVIII, as amended by sec-
6 tion 15001(a), is amended by inserting after section 1805
7 the following new section:

8 “MEDICARE PAYMENT REVIEW COMMISSION

9 “SEC. 1806. (a) ESTABLISHMENT.—There is hereby
10 established the Medicare Payment Review Commission (in
11 this section referred to as the ‘Commission’).

12 “(b) DUTIES.—

13 “(1) GENERAL DUTIES AND REPORTS.—

14 “(A) IN GENERAL.—The Commission shall
15 review, and make recommendations to Congress
16 concerning, payment policies under this title.

17 “(B) ANNUAL REPORTS.—By not later
18 than June 1 of each year, the Commission shall
19 submit a report to Congress containing an ex-
20 amination of issues affecting the medicare pro-
21 gram, including the implications of changes in
22 health care delivery in the United States and in
23 the market for health care services on the medi-
24 care program.

25 “(C) ADDITIONAL REPORTS.—The Com-
26 mission may submit to Congress from time to

1 time such other reports as the Commission
 2 deems appropriate. By not later than May 1,
 3 1997, the Commission shall submit to Congress
 4 a report on the matter described in paragraph
 5 (2)(G).

6 “(D) SECRETARIAL RESPONSE IN RULE-
 7 MAKING.—The Secretary shall respond to rec-
 8 ommendations of the Commission in notices of
 9 rulemaking proceedings under this title.

10 “(2) SPECIFIC DUTIES RELATING TO
 11 MEDICAREPLUS PROGRAM.—Specifically, the Com-
 12 mission shall review, with respect to the
 13 MedicarePlus program under part C—

14 “(A) the appropriateness of the methodol-
 15 ogy for making payment to plans under such
 16 program, including the making of differential
 17 payments and the distribution of differential
 18 updates among different payment areas);

19 “(B) the appropriateness of the mecha-
 20 nisms used to adjust payments for risk and the
 21 need to adjust such mechanisms to take into ac-
 22 count health status of beneficiaries;

23 “(C) the implications of risk selection both
 24 among MedicarePlus organizations and between

1 the MedicarePlus option and the non-
2 MedicarePlus option;

3 “(D) in relation to payment under part C,
4 the development and implementation of mecha-
5 nisms to assure the quality of care for those en-
6 rolled with MedicarePlus organizations;

7 “(E) the impact of the MedicarePlus pro-
8 gram on access to care for medicare bene-
9 ficiaries;

10 “(F) the feasibility and desirability of ex-
11 tending the rules for open enrollment that apply
12 during the transition period to apply in each
13 county during the first 2 years in which
14 MedicarePlus products are made available to in-
15 dividuals residing in the county; and

16 “(G) other major issues in implementation
17 and further development of the MedicarePlus
18 program.

19 “(3) SPECIFIC DUTIES RELATING TO THE
20 FAILSAFE BUDGET MECHANISM.—Specifically, the
21 Commission shall review, with respect to the failsafe
22 budget mechanism described in section 1895—

23 “(A) the appropriateness of the expendi-
24 ture projections by the Secretary under section
25 1895(c) for each medicare sector;

1 “(B) the appropriateness of the growth
2 factors for each sector and the ability to take
3 into account substitution across sectors;

4 “(C) the appropriateness of the mecha-
5 nisms for implementing reductions in payment
6 amounts for different sectors, including any ad-
7 justments to reflect changes in volume or inten-
8 sity resulting for any payment reductions;

9 “(D) the impact of the mechanism on pro-
10 vider participation in parts A and B and in the
11 MedicarePlus program; and

12 “(E) the appropriateness of the medicare
13 benefit budget (under section 1895(c)(2)(C) of
14 the Social Security Act), particularly for fiscal
15 years after fiscal year 2002.

16 “(4) SPECIFIC DUTIES RELATING TO THE FEE-
17 FOR-SERVICE SYSTEM.—Specifically, the Commission
18 shall review payment policies under parts A and B,
19 including—

20 “(A) the factors affecting expenditures for
21 services in different sectors, including the proc-
22 ess for updating hospital, physician, and other
23 fees,

24 “(B) payment methodologies; and

1 “(C) the impact of payment policies on ac-
2 cess and quality of care for medicare bene-
3 ficiaries.

4 “(5) SPECIFIC DUTIES RELATING TO INTER-
5 ACTION OF PAYMENT POLICIES WITH HEALTH CARE
6 DELIVERY GENERALLY.—Specifically the Commis-
7 sion shall review the effect of payment policies under
8 this title on the delivery of health care services
9 under this title and assess the implications of
10 changes in the health services market on the medi-
11 care program.

12 “(c) MEMBERSHIP.—

13 “(1) NUMBER AND APPOINTMENT.—The Com-
14 mission shall be composed of 15 members appointed
15 by the Comptroller General.

16 “(2) QUALIFICATIONS.—The membership of the
17 Commission shall include individuals with national
18 recognition for their expertise in health finance and
19 economics, actuarial science, health facility manage-
20 ment, health plans and integrated delivery systems,
21 reimbursement of health facilities, allopathic and os-
22 teopathic physicians, and other providers of services,
23 and other related fields, who provide a mix of dif-
24 ferent professionals, broad geographic representa-
25 tion, and a balance between urban and rural rep-

1 representatives, including physicians and other health
2 professionals, employers, third party payors, individ-
3 uals skilled in the conduct and interpretation of bio-
4 medical, health services, and health economics re-
5 search and expertise in outcomes and effectiveness
6 research and technology assessment. Such member-
7 ship shall also include representatives of consumers
8 and the elderly.

9 “(3) CONSIDERATIONS IN INITIAL APPOINT-
10 MENT.—To the extent possible, in first appointing
11 members to the Commission the Comptroller Gen-
12 eral shall consider appointing individuals who (as of
13 the date of the enactment of this section) were serv-
14 ing on the Prospective Payment Assessment Com-
15 mission or the Physician Payment Review Commis-
16 sion.

17 “(4) TERMS.—

18 “(A) IN GENERAL.—The terms of mem-
19 bers of the Commission shall be for 3 years ex-
20 cept that the Comptroller General shall des-
21 ignate staggered terms for the members first
22 appointed.

23 “(B) VACANCIES.—Any member appointed
24 to fill a vacancy occurring before the expiration
25 of the term for which the member’s predecessor

1 was appointed shall be appointed only for the
2 remainder of that term. A member may serve
3 after the expiration of that member’s term until
4 a successor has taken office. A vacancy in the
5 Commission shall be filled in the manner in
6 which the original appointment was made.

7 “(5) COMPENSATION.—While serving on the
8 business of the Commission (including traveltime), a
9 member of the Commission shall be entitled to com-
10 pensation at the per diem equivalent of the rate pro-
11 vided for level IV of the Executive Schedule under
12 section 5315 of title 5, United States Code; and
13 while so serving away from home and member’s reg-
14 ular place of business, a member may be allowed
15 travel expenses, as authorized by the Chairman of
16 the Commission. Physicians serving as personnel of
17 the Commission may be provided a physician com-
18 parability allowance by the Commission in the same
19 manner as Government physicians may be provided
20 such an allowance by an agency under section 5948
21 of title 5, United States Code, and for such purpose
22 subsection (i) of such section shall apply to the Com-
23 mission in the same manner as it applies to the Ten-
24 nessee Valley Authority. For purposes of pay (other
25 than pay of members of the Commission) and em-

1 employment benefits, rights, and privileges, all person-
2 nel of the Commission shall be treated as if they
3 were employees of the United States Senate.

4 “(6) CHAIRMAN; VICE CHAIRMAN.—The Comp-
5 troller General shall designate a member of the
6 Commission, at the time of appointment of the mem-
7 ber, as Chairman and a member as Vice Chairman
8 for that term of appointment.

9 “(7) MEETINGS.—The Commission shall meet
10 at the call of the Chairman.

11 “(d) DIRECTOR AND STAFF; EXPERTS AND CON-
12 SULTANTS.—Subject to such review as the Comptroller
13 General deems necessary to assure the efficient adminis-
14 tration of the Commission, the Commission may—

15 “(1) employ and fix the compensation of an Ex-
16 ecutive Director (subject to the approval of the
17 Comptroller General) and such other personnel as
18 may be necessary to carry out its duties (without re-
19 gard to the provisions of title 5, United States Code,
20 governing appointments in the competitive service);

21 “(2) seek such assistance and support as may
22 be required in the performance of its duties from ap-
23 propriate Federal departments and agencies;

24 “(3) enter into contracts or make other ar-
25 rangements, as may be necessary for the conduct of

1 the work of the Commission (without regard to sec-
2 tion 3709 of the Revised Statutes (41 U.S.C. 5));

3 “(4) make advance, progress, and other pay-
4 ments which relate to the work of the Commission;

5 “(5) provide transportation and subsistence for
6 persons serving without compensation; and

7 “(6) prescribe such rules and regulations as it
8 deems necessary with respect to the internal organi-
9 zation and operation of the Commission.

10 “(e) POWERS.—

11 “(1) OBTAINING OFFICIAL DATA.—The Com-
12 mission may secure directly from any department or
13 agency of the United States information necessary
14 to enable it to carry out this section. Upon request
15 of the Chairman, the head of that department or
16 agency shall furnish that information to the Com-
17 mission on an agreed upon schedule.

18 “(2) DATA COLLECTION.—In order to carry out
19 its functions, the Commission shall collect and as-
20 sess information to—

21 “(A) utilize existing information, both pub-
22 lished and unpublished, where possible, collected
23 and assessed either by its own staff or under
24 other arrangements made in accordance with
25 this section,

1 “(B) carry out, or award grants or con-
2 tracts for, original research and experimen-
3 tation, where existing information is inad-
4 equate, and

5 “(C) adopt procedures allowing any inter-
6 ested party to submit information for the Com-
7 mission’s use in making reports and rec-
8 ommendations.

9 “(3) ACCESS OF GAO TO INFORMATION.—The
10 Comptroller General shall have unrestricted access
11 to all deliberations, records, and data of the Com-
12 mission, immediately upon request.

13 “(4) PERIODIC AUDIT.—The Commission shall
14 be subject to periodic audit by the General Account-
15 ing Office.

16 “(f) AUTHORIZATION OF APPROPRIATIONS.—

17 “(1) REQUEST FOR APPROPRIATIONS.—The
18 Commission shall submit requests for appropriations
19 in the same manner as the Comptroller General sub-
20 mits requests for appropriations, but amounts ap-
21 propriated for the Commission shall be separate
22 from amounts appropriated for the Comptroller Gen-
23 eral.

24 “(2) AUTHORIZATION.—There are authorized to
25 be appropriated such sums as may be necessary to

1 carry out the provisions of this section. 60 percent
2 of such appropriation shall be payable from the Fed-
3 eral Hospital Insurance Trust Fund, and 40 percent
4 of such appropriation shall be payable from the Fed-
5 eral Supplementary Medical Insurance Trust
6 Fund.”.

7 (b) ABOLITION OF PROPAC AND PPRC.—

8 (1) PROPAC.—

9 (A) IN GENERAL.—Section 1886(e) (42
10 U.S.C. 1395ww(e)) is amended—

11 (i) by striking paragraphs (2) and (6);

12 and

13 (ii) in paragraph (3), by striking “(A)
14 The Commission” and all that follows
15 through “(B)”.

16 (B) CONFORMING AMENDMENT.—Section
17 1862 (42 U.S.C. 1395y) is amended by striking
18 “Prospective Payment Assessment Commis-
19 sion” each place it appears in subsection
20 (a)(1)(D) and subsection (i) and inserting
21 “Medicare Payment Review Commission”.

22 (2) PPRC.—

23 (A) IN GENERAL.—Title XVIII is amended
24 by striking section 1845 (42 U.S.C. 1395w–1).

25 (B) CONFORMING AMENDMENTS.—

1 (i) Section 1834(b)(2) (42 U.S.C.
2 1395m(b)(2)) is amended by striking
3 “Physician Payment Review Commission”
4 and inserting “Medicare Payment Review
5 Commission”.

6 (ii) Section 1842(b) (42 U.S.C.
7 1395u(b)) is amended by striking “Physi-
8 cian Payment Review Commission” each
9 place it appears in paragraphs (9)(D) and
10 (14)(C)(i) and inserting “Medicare Pay-
11 ment Review Commission”.

12 (iii) Section 1848 (42 U.S.C. 1395w–
13 4) is amended by striking “Physician Pay-
14 ment Review Commission” and inserting
15 “Medicare Payment Review Commission”
16 each place it appears in paragraph
17 (2)(A)(ii), (2)(B)(iii), and (5) of subsection
18 (c), subsection (d)(2)(F), paragraphs
19 (1)(B), (3), and (4)(A) of subsection (f),
20 and paragraphs (6)(C) and (7)(C) of sub-
21 section (g).

22 (c) EFFECTIVE DATE; TRANSITION.—

23 (1) IN GENERAL.—The Comptroller General
24 shall first provide for appointment of members to
25 the Medicare Payment Review Commission (in this

1 subsection referred to as “MPRC”) by not later
2 than March 31, 1996.

3 (2) TRANSITION.—Effective on a date (not later
4 than 30 days after the date a majority of members
5 of the MPRC have first been appointed, the Pro-
6 spective Payment Assessment Commission (in this
7 subsection referred to as “ProPAC”) and the Physi-
8 cian Payment Review Commission (in this subsection
9 referred to as “PPRC”), and amendments made by
10 subsection (b), are terminated. The Comptroller
11 General, to the maximum extent feasible, shall pro-
12 vide for the transfer to the MPRC of assets and
13 staff of ProPAC and PPRC, without any loss of
14 benefits or seniority by virtue of such transfers.
15 Fund balances available to the ProPAC or PPRC
16 for any period shall be available to the MPRC for
17 such period for like purposes.

18 (3) CONTINUING RESPONSIBILITY FOR RE-
19 PORTS.—The MPRC shall be responsible for the
20 preparation and submission of reports required by
21 law to be submitted (and which have not been sub-
22 mitted by the date of establishment of the MPRC)
23 by the ProPAC and PPRC, and, for this purpose,
24 any reference in law to either such Commission is

1 deemed, after the appointment of the MPRC, to
2 refer to the MPRC.

3 **SEC. 15032. COMMISSION ON THE EFFECT OF THE BABY**
4 **BOOM GENERATION ON THE MEDICARE PRO-**
5 **GRAM.**

6 (a) ESTABLISHMENT.—There is established a com-
7 mission to be known as the Commission on the Effect of
8 the Baby Boom Generation on the Medicare Program (in
9 this section referred to as the “Commission”).

10 (b) DUTIES.—

11 (1) IN GENERAL.—The Commission shall—

12 (A) examine the financial impact on the
13 medicare program of the significant increase in
14 the number of medicare eligible individuals
15 which will occur beginning approximately dur-
16 ing 2010 and lasting for approximately 25
17 years, and

18 (B) make specific recommendations to the
19 Congress respecting a comprehensive approach
20 to preserve the medicare program for the period
21 during which such individuals are eligible for
22 medicare.

23 (2) CONSIDERATIONS IN MAKING REC-
24 ommendations.—In making its recommendations,
25 the Commission shall consider the following:

1 (A) The amount and sources of Federal
2 funds to finance the medicare program, includ-
3 ing the potential use of innovative financing
4 methods.

5 (B) The most efficient and effective man-
6 ner of administering the program, including the
7 appropriateness of continuing the application of
8 the failsafe budget mechanism under section
9 1895 of the Social Security Act for fiscal years
10 after fiscal year 2002 and the appropriate long-
11 term growth rates for contributions electing
12 coverage under MedicarePlus under part C of
13 title XVIII of such Act.

14 (C) Methods used by other nations to re-
15 spond to comparable demographic patterns in
16 eligibility for health care benefits for elderly
17 and disabled individuals.

18 (D) Modifying age-based eligibility to cor-
19 respond to changes in age-based eligibility
20 under the OASDI program.

21 (E) Trends in employment-related health
22 care for retirees, including the use of medical
23 savings accounts and similar financing devices.

24 (c) MEMBERSHIP.—

1 (1) APPOINTMENT.—The Commission shall be
2 composed of 15 members appointed as follows:

3 (A) The President shall appoint 3 mem-
4 bers.

5 (B) The Majority Leader of the Senate
6 shall appoint, after consultation with the minor-
7 ity leader of the Senate, 6 members, of whom
8 not more than 4 may be of the same political
9 party.

10 (C) The Speaker of the House of Rep-
11 resentatives shall appoint, after consultation
12 with the minority leader of the House of Rep-
13 resentatives, 6 members, of whom not more
14 than 4 may be of the same political party.

15 (2) CHAIRMAN AND VICE CHAIRMAN.—The
16 Commission shall elect a Chairman and Vice Chair-
17 man from among its members.

18 (3) VACANCIES.—Any vacancy in the member-
19 ship of the Commission shall be filled in the manner
20 in which the original appointment was made and
21 shall not affect the power of the remaining members
22 to execute the duties of the Commission.

23 (4) QUORUM.—A quorum shall consist of 8
24 members of the Commission, except that 4 members
25 may conduct a hearing under subsection (e).

1 (5) MEETINGS.—The Commission shall meet at
2 the call of its Chairman or a majority of its mem-
3 bers.

4 (6) COMPENSATION AND REIMBURSEMENT OF
5 EXPENSES.—Members of the Commission are not
6 entitled to receive compensation for service on the
7 Commission. Members may be reimbursed for travel,
8 subsistence, and other necessary expenses incurred
9 in carrying out the duties of the Commission.

10 (d) STAFF AND CONSULTANTS.—

11 (1) STAFF.—The Commission may appoint and
12 determine the compensation of such staff as may be
13 necessary to carry out the duties of the Commission.
14 Such appointments and compensation may be made
15 without regard to the provisions of title 5, United
16 States Code, that govern appointments in the com-
17 petitive services, and the provisions of chapter 51
18 and subchapter III of chapter 53 of such title that
19 relate to classifications and the General Schedule
20 pay rates.

21 (2) CONSULTANTS.—The Commission may pro-
22 cure such temporary and intermittent services of
23 consultants under section 3109(b) of title 5, United
24 States Code, as the Commission determines to be
25 necessary to carry out the duties of the Commission.

1 (e) POWERS.—

2 (1) HEARINGS AND OTHER ACTIVITIES.—For
3 the purpose of carrying out its duties, the Commis-
4 sion may hold such hearings and undertake such
5 other activities as the Commission determines to be
6 necessary to carry out its duties.

7 (2) STUDIES BY GAO.—Upon the request of the
8 Commission, the Comptroller General shall conduct
9 such studies or investigations as the Commission de-
10 termines to be necessary to carry out its duties.

11 (3) COST ESTIMATES BY CONGRESSIONAL
12 BUDGET OFFICE.—

13 (A) Upon the request of the Commission,
14 the Director of the Congressional Budget Office
15 shall provide to the Commission such cost esti-
16 mates as the Commission determines to be nec-
17 essary to carry out its duties.

18 (B) The Commission shall reimburse the
19 Director of the Congressional Budget Office for
20 expenses relating to the employment in the of-
21 fice of the Director of such additional staff as
22 may be necessary for the Director to comply
23 with requests by the Commission under sub-
24 paragraph (A).

1 (4) DETAIL OF FEDERAL EMPLOYEES.—Upon
2 the request of the Commission, the head of any Fed-
3 eral agency is authorized to detail, without reim-
4 bursement, any of the personnel of such agency to
5 the Commission to assist the Commission in carry-
6 ing out its duties. Any such detail shall not interrupt
7 or otherwise affect the civil service status or privi-
8 leges of the Federal employee.

9 (5) TECHNICAL ASSISTANCE.—Upon the re-
10 quest of the Commission, the head of a Federal
11 agency shall provide such technical assistance to the
12 Commission as the Commission determines to be
13 necessary to carry out its duties.

14 (6) USE OF MAILS.—The Commission may use
15 the United States mails in the same manner and
16 under the same conditions as Federal agencies and
17 shall, for purposes of the frank, be considered a
18 commission of Congress as described in section 3215
19 of title 39, United States Code.

20 (7) OBTAINING INFORMATION.—The Commis-
21 sion may secure directly from any Federal agency
22 information necessary to enable it to carry out its
23 duties, if the information may be disclosed under
24 section 552 of title 5, United States Code. Upon re-
25 quest of the Chairman of the Commission, the head

1 of such agency shall furnish such information to the
2 Commission.

3 (8) ADMINISTRATIVE SUPPORT SERVICES.—

4 Upon the request of the Commission, the Adminis-
5 trator of General Services shall provide to the Com-
6 mission on a reimbursable basis such administrative
7 support services as the Commission may request.

8 (9) ACCEPTANCE OF DONATIONS.—The Com-
9 mission may accept, use, and dispose of gifts or do-
10 nations of services or property.

11 (10) PRINTING.—For purposes of costs relating
12 to printing and binding, including the cost of per-
13 sonnel detailed from the Government Printing Of-
14 fice, the Commission shall be deemed to be a com-
15 mittee of the Congress.

16 (f) REPORT.—Not later than May 1, 1997, the Com-
17 mission shall submit to Congress a report containing its
18 findings and recommendations regarding how to protect
19 and preserve the medicare program in a financially solvent
20 manner until 2030 (or, if later, throughout the period of
21 projected solvency of the Federal Old-Age and Survivors
22 Insurance Trust Fund). The report shall include detailed
23 recommendations for appropriate legislative initiatives re-
24 specting how to accomplish this objective.

1 (g) TERMINATION.—The Commission shall terminate
2 60 days after the date of submission of the report required
3 in subsection (f).

4 (h) AUTHORIZATION OF APPROPRIATIONS.—There
5 are authorized to be appropriated \$1,500,000 to carry out
6 this section. Amounts appropriated to carry out this sec-
7 tion shall remain available until expended.

8 **SEC. 15033. CHANGE IN APPOINTMENT OF ADMINISTRATOR**
9 **OF HCFA.**

10 (a) IN GENERAL.—Section 1117 (42 U.S.C. 1317)
11 is amended by striking “President by and with the advice
12 and consent of the Senate” and inserting “Secretary of
13 Health and Human Services”.

14 (b) EFFECTIVE DATE.—The amendment made by
15 subsection (a) shall take effect on the date of the enact-
16 ment of this Act and shall apply to Administrators ap-
17 pointed on or after the date of the enactment of this Act.

18 **PART 5—TREATMENT OF HOSPITALS WHICH PAR-**
19 **TICIPATE IN PROVIDER-SPONSORED ORGA-**
20 **NIZATIONS**

21 **SEC. 15041. TREATMENT OF HOSPITALS WHICH PARTICI-**
22 **PATE IN PROVIDER-SPONSORED ORGANIZA-**
23 **TIONS.**

24 (a) IN GENERAL.—Section 501 of the Internal Reve-
25 nue Code of 1986 (relating to exemption from tax on cor-

1 porations, certain trusts, etc.) is amended by redesignat-
 2 ing subsection (n) as subsection (o) and by inserting after
 3 subsection (m) the following new subsection:

4 “(n) TREATMENT OF HOSPITALS PARTICIPATING IN
 5 PROVIDER-SPONSORED ORGANIZATIONS.—An organiza-
 6 tion shall not fail to be treated as organized and operated
 7 exclusively for a charitable purpose for purposes of sub-
 8 section (c)(3) solely because a hospital which is owned and
 9 operated by such organization participates in a provider-
 10 sponsored organization (as defined in section 1854(a)(1)
 11 of the Social Security Act), whether or not the provider-
 12 sponsored organization is exempt from tax. For purposes
 13 of subsection (c)(3), any person with a material financial
 14 interest in such a provider-sponsored organization shall be
 15 treated as a private shareholder or individual with respect
 16 to the hospital.”

17 (b) EFFECTIVE DATE.—The amendment made by
 18 subsection (a) shall take effect on the date of the enact-
 19 ment of this Act.

1 **Subtitle B—Preventing Fraud and** 2 **Abuse**

3 **PART 1—GENERAL PROVISIONS**

4 **SEC. 15101. INCREASING AWARENESS OF FRAUD AND** 5 **ABUSE.**

6 (a) **BENEFICIARY OUTREACH EFFORTS.**—The Sec-
7 retary of Health and Human Services (acting through the
8 Administrator of the Health Care Financing Administra-
9 tion and the Inspector General of the Department of
10 Health and Human Services) shall make ongoing efforts
11 (through public service announcements, publications, and
12 other appropriate methods) to alert individuals entitled to
13 benefits under the medicare program of the existence of
14 fraud and abuse committed against the program and the
15 costs to the program of such fraud and abuse, and of the
16 existence of the toll-free telephone line operated by the
17 Secretary to receive information on fraud and abuse com-
18 mitted against the program.

19 (b) **CLARIFICATION OF REQUIREMENT TO PROVIDE**
20 **EXPLANATION OF MEDICARE BENEFITS.**—The Secretary
21 shall provide an explanation of benefits under the medi-
22 care program with respect to each item or service for
23 which payment may be made under the program which
24 is furnished to an individual, without regard to whether

1 or not a deductible or coinsurance may be imposed against
2 the individual with respect to the item or service.

3 (c) PROVIDER OUTREACH EFFORTS; PUBLICATION
4 OF FRAUD ALERTS.—

5 (1) SPECIAL FRAUD ALERTS.—

6 (A) IN GENERAL.—

7 (i) REQUEST FOR SPECIAL FRAUD
8 ALERTS.—Any person may present, at any
9 time, a request to the Secretary to issue
10 and publish a special fraud alert.

11 (ii) SPECIAL FRAUD ALERT DE-
12 FINED.—In this section, a “special fraud
13 alert” is a notice which informs the public
14 of practices which the Secretary considers
15 to be suspect or of particular concern
16 under the medicare program or a State
17 health care program (as defined in section
18 1128(h) of the Social Security Act).

19 (B) ISSUANCE AND PUBLICATION OF SPE-
20 CIAL FRAUD ALERTS.—

21 (i) INVESTIGATION.—Upon receipt of
22 a request for a special fraud alert under
23 subparagraph (A), the Secretary shall in-
24 vestigate the subject matter of the request
25 to determine whether a special fraud alert

1 should be issued. If appropriate, the Sec-
 2 retary (in consultation with the Attorney
 3 General) shall issue a special fraud alert in
 4 response to the request. All special fraud
 5 alerts issued pursuant to this subpara-
 6 graph shall be published in the Federal
 7 Register.

8 (ii) CRITERIA FOR ISSUANCE.—In de-
 9 termining whether to issue a special fraud
 10 alert upon a request under subparagraph
 11 (A), the Secretary may consider—

12 (I) whether and to what extent
 13 the practices that would be identified
 14 in the special fraud alert may result
 15 in any of the consequences described
 16 in 15214(b); and

17 (II) the extent and frequency of
 18 the conduct that would be identified
 19 in the special fraud alert.

20 (2) PUBLICATION OF ALL HCFA FRAUD ALERTS
 21 IN FEDERAL REGISTER.—Each notice issued by the
 22 Health Care Financing Administration which in-
 23 forms the public of practices which the Secretary
 24 considers to be suspect or of particular concern
 25 under the medicare program or a State health care

1 program (as defined in section 1128(h) of the Social
2 Security Act) shall be published in the Federal Reg-
3 ister, without regard to whether or not the notice
4 is issued by a regional office of the Health Care Fi-
5 nancing Administration.

6 **SEC. 15102. BENEFICIARY INCENTIVE PROGRAMS.**

7 (a) PROGRAM TO COLLECT INFORMATION ON FRAUD
8 AND ABUSE.—

9 (1) ESTABLISHMENT OF PROGRAM.—Not later
10 than 3 months after the date of the enactment of
11 this Act, the Secretary of Health and Human Serv-
12 ices (hereinafter in this subtitle referred to as the
13 “Secretary”) shall establish a program under which
14 the Secretary shall encourage individuals to report
15 to the Secretary information on individuals and enti-
16 ties who are engaging or who have engaged in acts
17 or omissions which constitute grounds for the im-
18 position of a sanction under section 1128, section
19 1128A, or section 1128B of the Social Security Act,
20 or who have otherwise engaged in fraud and abuse
21 against the medicare program for which there is a
22 sanction provided under law. The program shall dis-
23 courage provision of, and not consider, information
24 which is frivolous or otherwise not relevant or mate-
25 rial to the imposition of such a sanction.

1 (2) PAYMENT OF PORTION OF AMOUNTS COL-
 2 LECTED.—If an individual reports information to
 3 the Secretary under the program established under
 4 paragraph (1) which serves as the basis for the col-
 5 lection by the Secretary or the Attorney General of
 6 any amount of at least \$100 (other than any
 7 amount paid as a penalty under section 1128B of
 8 the Social Security Act), the Secretary may pay a
 9 portion of the amount collected to the individual
 10 (under procedures similar to those applicable under
 11 section 7623 of the Internal Revenue Code of 1986
 12 to payments to individuals providing information on
 13 violations of such Code).

14 (b) PROGRAM TO COLLECT INFORMATION ON PRO-
 15 GRAM EFFICIENCY.—

16 (1) ESTABLISHMENT OF PROGRAM.—Not later
 17 than 3 months after the date of the enactment of
 18 this Act, the Secretary shall establish a program
 19 under which the Secretary shall encourage individ-
 20 uals to submit to the Secretary suggestions on meth-
 21 ods to improve the efficiency of the medicare pro-
 22 gram.

23 (2) PAYMENT OF PORTION OF PROGRAM SAV-
 24 INGS.—If an individual submits a suggestion to the
 25 Secretary under the program established under

1 paragraph (1) which is adopted by the Secretary and
 2 which results in savings to the program, the Sec-
 3 retary may make a payment to the individual of
 4 such amount as the Secretary considers appropriate.

5 **SEC. 15103. INTERMEDIATE SANCTIONS FOR MEDICARE**
 6 **HEALTH MAINTENANCE ORGANIZATIONS.**

7 (a) APPLICATION OF INTERMEDIATE SANCTIONS FOR
 8 ANY PROGRAM VIOLATIONS.—

9 (1) IN GENERAL.—Section 1876(i)(1) (42
 10 U.S.C. 1395mm(i)(1)) is amended by striking “the
 11 Secretary may terminate” and all that follows and
 12 inserting the following: “in accordance with proce-
 13 dures established under paragraph (9), the Secretary
 14 may at any time terminate any such contract or may
 15 impose the intermediate sanctions described in para-
 16 graph (6)(B) or (6)(C) (whichever is applicable) on
 17 the eligible organization if the Secretary determines
 18 that the organization—

19 “(A) has failed substantially to carry out the
 20 contract;

21 “(B) is carrying out the contract in a manner
 22 inconsistent with the efficient and effective adminis-
 23 tration of this section;

1 “(C) is operating in a manner that is not in the
2 best interests of the individuals covered under the
3 contract; or

4 “(D) no longer substantially meets the applica-
5 ble conditions of subsections (b), (c), and (e).”.

6 (2) OTHER INTERMEDIATE SANCTIONS FOR
7 MISCELLANEOUS PROGRAM VIOLATIONS.—Section
8 1876(i)(6) (42 U.S.C. 1395mm(i)(6)) is amended by
9 adding at the end the following new subparagraph:
10 “(C) In the case of an eligible organization for which
11 the Secretary makes a determination under paragraph (1)
12 the basis of which is not described in subparagraph (A),
13 the Secretary may apply the following intermediate sanc-
14 tions:

15 “(i) civil money penalties of not more than
16 \$25,000 for each determination under paragraph (1)
17 if the deficiency that is the basis of the determina-
18 tion has directly adversely affected (or has the sub-
19 stantial likelihood of adversely affecting) an individ-
20 ual covered under the organization’s contract;

21 “(ii) civil money penalties of not more than
22 \$10,000 for each week beginning after the initiation
23 of procedures by the Secretary under paragraph (9)
24 during which the deficiency that is the basis of a de-
25 termination under paragraph (1) exists; and

1 “(iii) suspension of enrollment of individuals
2 under this section after the date the Secretary noti-
3 fies the organization of a determination under para-
4 graph (1) and until the Secretary is satisfied that
5 the deficiency that is the basis for the determination
6 has been corrected and is not likely to recur.”.

7 (3) PROCEDURES FOR IMPOSING SANCTIONS.—
8 Section 1876(i) (42 U.S.C. 1395mm(i)) is amended
9 by adding at the end the following new paragraph:
10 “(9) The Secretary may terminate a contract with an
11 eligible organization under this section or may impose the
12 intermediate sanctions described in paragraph (6) on the
13 organization in accordance with formal investigation and
14 compliance procedures established by the Secretary under
15 which—

16 “(A) the Secretary provides the organization
17 with the opportunity to develop and implement a
18 corrective action plan to correct the deficiencies that
19 were the basis of the Secretary’s determination
20 under paragraph (1);

21 “(B) the Secretary shall impose more severe
22 sanctions on organizations that have a history of de-
23 ficiencies or that have not taken steps to correct de-
24 ficiencies the Secretary has brought to their atten-
25 tion;

1 “(C) there are no unreasonable or unnecessary
2 delays between the finding of a deficiency and the
3 imposition of sanctions; and

4 “(D) the Secretary provides the organization
5 with reasonable notice and opportunity for hearing
6 (including the right to appeal an initial decision) be-
7 fore imposing any sanction or terminating the con-
8 tract.”.

9 (4) CONFORMING AMENDMENTS.—(A) Section
10 1876(i)(6)(B) (42 U.S.C. 1395mm(i)(6)(B)) is
11 amended by striking the second sentence.

12 (B) Section 1876(i)(6) (42 U.S.C.
13 1395mm(i)(6)) is further amended by adding at the
14 end the following new subparagraph:

15 “(D) The provisions of section 1128A (other than
16 subsections (a) and (b)) shall apply to a civil money pen-
17 alty under subparagraph (A) or (B) in the same manner
18 as they apply to a civil money penalty or proceeding under
19 section 1128A(a).”.

20 (b) EFFECTIVE DATE.—The amendments made by
21 this section shall apply with respect to contract years be-
22 ginning on or after January 1, 1996.

23 **SEC. 15104. VOLUNTARY DISCLOSURE PROGRAM.**

24 Title XI (42 U.S.C. 1301 et seq.) is amended by in-
25 serting after section 1128B the following new section:

1 “VOLUNTARY DISCLOSURE OF ACTS OR OMISSIONS

2 “SEC. 1129. (a) ESTABLISHMENT OF VOLUNTARY
3 DISCLOSURE PROGRAM.—Not later than 3 months after
4 the date of the enactment of this section, the Secretary
5 shall establish a program to encourage individuals and en-
6 tities to voluntarily disclose to the Secretary information
7 on acts or omissions of the individual or entity which con-
8 stitute grounds for the imposition of a sanction described
9 in section 1128, 1128A, or 1128B.

10 “(b) EFFECT OF VOLUNTARY DISCLOSURE.—If an
11 individual or entity voluntarily discloses information with
12 respect to an act or omission to the Secretary under sub-
13 section (a), the following rules shall apply:

14 “(1) The Secretary may waive, reduce, or other-
15 wise mitigate any sanction which would otherwise be
16 applicable to the individual or entity under section
17 1128, 1128A, or 1128B as a result of the act or
18 omission involved.

19 “(2) No qui tam action may be brought pursu-
20 ant to chapter 37 of title 31, United States Code,
21 against the individual or entity with respect to the
22 act or omission involved.”.

23 **SEC. 15105. REVISIONS TO CURRENT SANCTIONS.**

24 (a) DOUBLING THE AMOUNT OF CIVIL MONETARY
25 PENALTIES.—The maximum amount of civil monetary

1 penalties specified in section 1128A of the Social Security
2 Act or under title XVIII of such Act (as in effect on the
3 day before the date of the enactment of this Act) shall,
4 effective for violations occurring after the date of the en-
5 actment of this Act, be double the amount otherwise pro-
6 vided as of such date.

7 (b) ESTABLISHMENT OF MINIMUM PERIOD OF EX-
8 CLUSION FOR CERTAIN INDIVIDUALS AND ENTITIES SUB-
9 JECT TO PERMISSIVE EXCLUSION.—Section 1128(c)(3)
10 (42 U.S.C. 1320a–7(c)(3)) is amended by adding at the
11 end the following new subparagraphs:

12 “(D) In the case of an exclusion of an individual or
13 entity under paragraph (1), (2), or (3) of subsection (b),
14 the period of the exclusion shall be 3 years, unless the
15 Secretary determines in accordance with regulations that
16 a shorter period is appropriate because of mitigating cir-
17 cumstances or that a longer period is appropriate because
18 of aggravating circumstances.

19 “(E) In the case of an exclusion of an individual or
20 entity under subsection (b)(4) or (b)(5), the period of the
21 exclusion shall not be less than the period during which
22 the individual’s or entity’s license to provide health care
23 is revoked, suspended, or surrendered, or the individual
24 or the entity is excluded or suspended from a Federal or
25 State health care program.

1 “(F) In the case of an exclusion of an individual or
2 entity under subsection (b)(6)(B), the period of the exclu-
3 sion shall be not less than 1 year.”.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply with respect to acts or omissions
6 occurring on or after January 1, 1996.

7 **SEC. 15106. DIRECT SPENDING FOR ANTI-FRAUD ACTIVI-**
8 **TIES UNDER MEDICARE.**

9 (a) ESTABLISHMENT OF MEDICARE INTEGRITY PRO-
10 GRAM.—Title XVIII is amended by adding at the end the
11 following new section:

12 “MEDICARE INTEGRITY PROGRAM

13 “SEC. 1893. (a) ESTABLISHMENT OF PROGRAM.—
14 There is hereby established the Medicare Integrity Pro-
15 gram (hereafter in this section referred to as the ‘Pro-
16 gram’) under which the Secretary shall promote the integ-
17 rity of the medicare program by entering into contracts
18 in accordance with this section with eligible private entities
19 to carry out the activities described in subsection (b).

20 “(b) ACTIVITIES DESCRIBED.—The activities de-
21 scribed in this subsection are as follows:

22 “(1) Review of activities of providers of services
23 or other individuals and entities furnishing items
24 and services for which payment may be made under
25 this title (including skilled nursing facilities and
26 home health agencies), including medical and utiliza-

1 tion review and fraud review (employing similar
2 standards, processes, and technologies used by pri-
3 vate health plans, including equipment and software
4 technologies which surpass the capability of the
5 equipment and technologies used in the review of
6 claims under this title as of the date of the enact-
7 ment of this section).

8 “(2) Audit of cost reports.

9 “(3) Determinations as to whether payment
10 should not be, or should not have been, made under
11 this title by reason of section 1862(b), and recovery
12 of payments that should not have been made.

13 “(4) Education of providers of services, bene-
14 ficiaries, and other persons with respect to payment
15 integrity and benefit quality assurance issues.

16 “(c) ELIGIBILITY OF ENTITIES.—An entity is eligible
17 to enter into a contract under the Program to carry out
18 any of the activities described in subsection (b) if—

19 “(1) the entity has demonstrated capability to
20 carry out such activities;

21 “(2) in carrying out such activities, the entity
22 agrees to cooperate with the Inspector General of
23 the Department of Health and Human Services, the
24 Attorney General of the United States, and other
25 law enforcement agencies, as appropriate, in the in-

1 investigation and deterrence of fraud and abuse in re-
2 lation to this title and in other cases arising out of
3 such activities;

4 “(3) the entity’s financial holdings, interests, or
5 relationships will not interfere with its ability to per-
6 form the functions to be required by the contract in
7 an effective and impartial manner; and

8 “(4) the entity meets such other requirements
9 as the Secretary may impose.

10 “(d) PROCESS FOR ENTERING INTO CONTRACTS.—
11 The Secretary shall enter into contracts under the Pro-
12 gram in accordance with such procedures as the Secretary
13 may by regulation establish, except that such procedures
14 shall include the following:

15 “(1) The Secretary shall determine the appro-
16 priate number of separate contracts which are nec-
17 essary to carry out the Program and the appropriate
18 times at which the Secretary shall enter into such
19 contracts.

20 “(2) The provisions of section 1153(e)(1) shall
21 apply to contracts and contracting authority under
22 this section, except that competitive procedures must
23 be used when entering into new contracts under this
24 section, or at any other time considered appropriate
25 by the Secretary.

1 “(3) A contract under this section may be re-
2 newed without regard to any provision of law requir-
3 ing competition if the contractor has met or ex-
4 ceeded the performance requirements established in
5 the current contract.

6 “(e) LIMITATION ON CONTRACTOR LIABILITY.—The
7 Secretary shall by regulation provide for the limitation of
8 a contractor’s liability for actions taken to carry out a con-
9 tract under the Program, and such regulation shall, to the
10 extent the Secretary finds appropriate, employ the same
11 or comparable standards and other substantive and proce-
12 dural provisions as are contained in section 1157.

13 “(f) TRANSFER OF AMOUNTS TO MEDICARE ANTI-
14 FRAUD AND ABUSE TRUST FUND.—For each fiscal year,
15 the Secretary shall transfer from the Federal Hospital In-
16 surance Trust Fund and the Federal Supplementary Med-
17 ical Insurance Trust Fund to the Medicare Anti-Fraud
18 and Abuse Trust Fund under subsection (g) such amounts
19 as are necessary to carry out the activities described in
20 subsection (b). Such transfer shall be in an allocation as
21 reasonably reflects the proportion of such expenditures as-
22 sociated with part A and part B.

23 “(g) MEDICARE ANTI-FRAUD AND ABUSE TRUST
24 FUND.—

25 “(1) ESTABLISHMENT.—

1 “(A) IN GENERAL.—There is hereby estab-
 2 lished in the Treasury of the United States the
 3 Anti-Fraud and Abuse Trust Fund (hereafter
 4 in this subsection referred to as the ‘Trust
 5 Fund’). The Trust Fund shall consist of such
 6 gifts and bequests as may be made as provided
 7 in subparagraph (B) and such amounts as may
 8 be deposited in the Trust Fund as provided in
 9 subsection (f), paragraph (3), and title XI.

10 “(B) AUTHORIZATION TO ACCEPT GIFTS
 11 AND BEQUESTS.—The Trust Fund is author-
 12 ized to accept on behalf of the United States
 13 money gifts and bequests made unconditionally
 14 to the Trust Fund, for the benefit of the Trust
 15 Fund or any activity financed through the
 16 Trust Fund.

17 “(2) INVESTMENT.—

18 “(A) IN GENERAL.—The Secretary of the
 19 Treasury shall invest such amounts of the Fund
 20 as such Secretary determines are not required
 21 to meet current withdrawals from the Fund in
 22 government account serial securities.

23 “(B) USE OF INCOME.—Any interest de-
 24 rived from investments under subparagraph (A)
 25 shall be credited to the Fund.

1 “(3) AMOUNTS DEPOSITED INTO TRUST
2 FUND.—In addition to amounts transferred under
3 subsection (f), there shall be deposited in the Trust
4 Fund—

5 “(A) that portion of amounts recovered in
6 relation to section 1128A arising out of a claim
7 under title XVIII as remains after application
8 of subsection (f)(2) (relating to repayment of
9 the Federal Hospital Insurance Trust Fund or
10 the Federal Supplementary Medical Insurance
11 Trust Fund) of that section, as may be applica-
12 ble,

13 “(B) fines imposed under section 1128B
14 arising out of a claim under this title, and

15 “(C) penalties and damages imposed (other
16 than funds awarded to a relator or for restitu-
17 tion) under sections 3729 through 3732 of title
18 31, United States Code (pertaining to false
19 claims) in cases involving claims relating to pro-
20 grams under title XVIII, XIX, or XXI.

21 “(4) DIRECT APPROPRIATION OF FUNDS TO
22 CARRY OUT PROGRAM.—

23 “(A) IN GENERAL.—There are appro-
24 priated from the Trust Fund for each fiscal
25 year such amounts as are necessary to carry

1 out the Medicare Integrity Program under this
2 section, subject to subparagraph (B).

3 “(B) AMOUNTS SPECIFIED.—The amount
4 appropriated under subparagraph (A) for a fis-
5 cal year is as follows:

6 “(i) For fiscal year 1996, such
7 amount shall be not less than
8 \$430,000,000 and not more than
9 \$440,000,000.

10 “(ii) For fiscal year 1997, such
11 amount shall be not less than
12 \$490,000,000 and not more than
13 \$500,000,000.

14 “(iii) For fiscal year 1998, such
15 amount shall be not less than
16 \$550,000,000 and not more than
17 \$560,000,000.

18 “(iv) For fiscal year 1999, such
19 amount shall be not less than
20 \$620,000,000 and not more than
21 \$630,000,000.

22 “(v) For fiscal year 2000, such
23 amount shall be not less than
24 \$670,000,000 and not more than
25 \$680,000,000.

1 “(vi) For fiscal year 2001, such
2 amount shall be not less than
3 \$690,000,000 and not more than
4 \$700,000,000.

5 “(vii) For fiscal year 2002, such
6 amount shall be not less than
7 \$710,000,000 and not more than
8 \$720,000,000.

9 “(5) ANNUAL REPORT.—The Secretary shall
10 submit an annual report to Congress on the amount
11 of revenue which is generated and disbursed by the
12 Trust Fund in each fiscal year.”.

13 (b) ELIMINATION OF FI AND CARRIER RESPONSIBIL-
14 ITY FOR CARRYING OUT ACTIVITIES SUBJECT TO PRO-
15 GRAM.—

16 (1) RESPONSIBILITIES OF FISCAL
17 INTERMEDIARIES UNDER PART A.—Section 1816
18 (42 U.S.C. 1395h) is amended by adding at the end
19 the following new subsection:

20 “(l) No agency or organization may carry out (or re-
21 ceive payment for carrying out) any activity pursuant to
22 an agreement under this section to the extent that the ac-
23 tivity is carried out pursuant to a contract under the Med-
24 icare Integrity Program under section 1893.”.

1 (2) RESPONSIBILITIES OF CARRIERS UNDER
2 PART B.—Section 1842(c) (42 U.S.C. 1395u(c)) is
3 amended by adding at the end the following new
4 paragraph:

5 “(6) No carrier may carry out (or receive payment
6 for carrying out) any activity pursuant to a contract under
7 this subsection to the extent that the activity is carried
8 out pursuant to a contract under the Medicare Integrity
9 Program under section 1893.”.

10 (c) CONFORMING AMENDMENT.—Section
11 1128A(f)(3) (42 U.S.C. 1320a–7a(f)(3)) is amended by
12 striking “as miscellaneous receipts of the Treasury of the
13 United States” and inserting “in the Anti-Fraud and
14 Abuse Trust Fund established under section 1893(g)”.

15 (d) DIRECT SPENDING FOR MEDICARE-RELATED AC-
16 TIVITIES OF INSPECTOR GENERAL.—Section 1893, as
17 added by subsection (a), is amended by adding at the end
18 the following new subsection:

19 “(h) DIRECT SPENDING FOR MEDICARE-RELATED
20 ACTIVITIES OF INSPECTOR GENERAL.—

21 “(1) IN GENERAL.—There are appropriated
22 from the Federal Hospital Insurance Trust Fund
23 and the Federal Supplementary Medical Insurance
24 Trust Fund to the Inspector General of the Depart-
25 ment of Health and Human Services for each fiscal

1 year such amounts as are necessary to enable the
2 Inspector General to carry out activities relating to
3 the medicare program (as described in paragraph
4 (2)), subject to paragraph (3).

5 “(2) ACTIVITIES DESCRIBED.—The activities
6 described in this paragraph are as follows:

7 “(A) Prosecuting medicare-related matters
8 through criminal, civil, and administrative pro-
9 ceedings.

10 “(B) Conducting investigations relating to
11 the medicare program.

12 “(C) Performing financial and performance
13 audits of programs and operations relating to
14 the medicare program.

15 “(D) Performing inspections and other
16 evaluations relating to the medicare program.

17 “(E) Conducting provider and consumer
18 education activities regarding the requirements
19 of this title.

20 “(3) AMOUNTS SPECIFIED.—The amount ap-
21 propriated under paragraph (1) for a fiscal year is
22 as follows:

23 “(A) For fiscal year 1996, such amount
24 shall be \$130,000,000.

1 “(B) For fiscal year 1997, such amount
2 shall be \$181,000,000.

3 “(C) For fiscal year 1998, such amount
4 shall be \$204,000,000.

5 “(D) For each subsequent fiscal year, the
6 amount appropriated for the previous fiscal
7 year, increased by the percentage increase in
8 aggregate expenditures under this title for the
9 fiscal year involved over the previous fiscal year.

10 “(4) ALLOCATION OF PAYMENTS AMONG TRUST
11 FUNDS.—The appropriations made under paragraph
12 (1) shall be in an allocation as reasonably reflects
13 the proportion of such expenditures associated with
14 part A and part B.”.

15 **SEC. 15107. PERMITTING CARRIERS TO CARRY OUT PRIOR**
16 **AUTHORIZATION FOR CERTAIN ITEMS OF DU-**
17 **RABLE MEDICAL EQUIPMENT.**

18 (a) IN GENERAL.—Section 1834(a)(15) (42 U.S.C.
19 1395m(a)(15)), as amended by section 135(b) of the So-
20 cial Security Act Amendments of 1994, is amended by
21 adding at the end the following new subparagraphs:

22 “(D) APPLICATION BY CARRIERS.—A car-
23 rier may develop (and periodically update) a list
24 of items under subparagraph (A) and a list of
25 suppliers under subparagraph (B) in the same

1 manner as the Secretary may develop (and peri-
2 odically update) such lists.

3 “(E) WAIVER OF PUBLICATION REQUIRE-
4 MENT.—A carrier may make an advance deter-
5 mination under subparagraph (C) with respect
6 to an item or supplier on a list developed by the
7 Secretary or the carrier without regard to
8 whether or not the Secretary has promulgated
9 a regulation with respect to the list, except that
10 the carrier may not make such an advance de-
11 termination with respect to an item or supplier
12 on a list until the expiration of the 30-day pe-
13 riod beginning on the date the Secretary or the
14 carrier places the item or supplier on the list.”.

15 (b) EFFECTIVE DATE.—The amendment made by
16 subsection (a) shall take effect as if included in the enact-
17 ment of the Social Security Act Amendments of 1994.

18 **SEC. 15108. NATIONAL HEALTH CARE ANTI-FRAUD TASK**
19 **FORCE.**

20 (a) ESTABLISHMENT.—The Attorney General, in
21 consultation with the Secretary of Health and Human
22 Services, shall establish a national health care anti-fraud
23 task force (in this section referred to as the “task force”).
24 The Attorney General shall establish the task force within
25 120 days after the date of the enactment of this Act.

1 (b) COMPOSITION.—The task force shall include rep-
2 representatives of Federal agencies involved in the investiga-
3 tion and prosecution of persons violating laws relating to
4 health care fraud and abuse, including at least one rep-
5 resentative from each of the following agencies:

6 (1) The Department of Justice and the Federal
7 Bureau of Investigation.

8 (2) The Department of Health and Human
9 Services and the Office of the Inspector General
10 within the Department.

11 (3) The office in the Department of Defense re-
12 sponsible for administration of the CHAMPUS pro-
13 gram.

14 (4) The Department of Veterans' Affairs.

15 (5) The United States Postal Inspection Serv-
16 ice.

17 (6) The Internal Revenue Service.

18 The Attorney General (or the designee of the Attorney
19 General) shall serve as chair of the task force.

20 (c) DUTIES.—The task force shall coordinate Federal
21 law enforcement activities relating to health care fraud
22 and abuse in order to better control fraud and abuse in
23 the delivery of health care in the United States. Specifi-
24 cally, the task force shall coordinate activities—

1 (1) in order to assure the effective targeting
2 and investigation of persons who organize, direct, fi-
3 nance, or otherwise knowingly engage in health care
4 fraud, and

5 (2) in order to assure full and effective coopera-
6 tion between Federal and State agencies involved in
7 health care fraud investigations.

8 (d) STAFF.—Each member of the task force who rep-
9 resents an agency shall be responsible for providing for
10 the detail (from the agency) of at least one full-time staff
11 person to staff the task force. Such detail shall be without
12 change in salary, compensation, benefits, and other em-
13 ployment-related matters.

14 **SEC. 15109. STUDY OF ADEQUACY OF PRIVATE QUALITY AS-**
15 **SURANCE PROGRAMS.**

16 (a) IN GENERAL.—The Administrator of the Health
17 Care Financing Administration (acting through the Direc-
18 tor of the Office of Research and Demonstrations) shall
19 enter into an agreement with a private entity to conduct
20 a study during the 5-year period beginning on the date
21 of the enactment of this Act of the adequacy of the quality
22 assurance programs and consumer protections used by the
23 MedicarePlus program under part C of title XVIII of the
24 Social Security Act (as inserted by section 15002(a)), and
25 shall include in the study an analysis of the effectiveness

1 of such programs in protecting plan enrollees against the
2 risk of insufficient provision of benefits which may result
3 from utilization controls.

4 (b) REPORT.—Not later than 6 months after the con-
5 clusion of the 5-year period described in subsection (a),
6 the Administrator shall submit a report to Congress on
7 the study conducted under subsection (a).

8 **SEC. 15110. PENALTY FOR FALSE CERTIFICATION FOR**
9 **HOME HEALTH SERVICES.**

10 (a) IN GENERAL.—Section 1128A(b) (42 U.S.C.
11 1320a–7a(b)) is amended by adding at the end the follow-
12 ing new paragraph:

13 “(3)(A) Any physician who executes a document de-
14 scribed in subparagraph (B) with respect to an individual
15 knowing that all of the requirements referred to in such
16 subparagraph are not met with respect to the individual
17 shall be subject to a civil monetary penalty of not more
18 than the greater of—

19 “(i) \$5,000, or

20 “(ii) three times the amount of the payments
21 under title XVIII for home health services which are
22 made pursuant to such certification.

23 “(B) A document described in this subparagraph is
24 any document that certifies, for purposes of title XVIII,
25 that an individual meets the requirements of section

1 1814(a)(2)(C) or 1835(a)(2)(A) in the case of home
2 health services furnished to the individual.”.

3 (b) EFFECTIVE DATE.—The amendment made by
4 subsection (a) shall apply to certifications made on or
5 after the date of the enactment of this Act.

6 **SEC. 15111. PILOT PROJECTS.**

7 The Secretary of Health and Human Services shall
8 establish and operate 5 pilot projects (in various geo-
9 graphic regions of the United States) under which the Sec-
10 retary shall implement innovative approaches to monitor
11 payment claims under the medicare program to detect
12 those claims that are wasteful or fraudulent.

13 **PART 2—CRIMINAL LAW PROVISIONS**

14 **SEC. 15121. OFFENSES INVOLVING FRAUD, FALSE STATE-**
15 **MENT, THEFT, OR EMBEZZLEMENT.**

16 (a) IN GENERAL.—Part A of title XI is amended by
17 inserting after section 1128B the following:

18 “OFFENSES INVOLVING FRAUD, FALSE STATEMENT,
19 THEFT, OR EMBEZZLEMENT

20 “SEC. 1128C. (a) FRAUD.—Whoever knowingly and
21 willfully executes, or attempts to execute, a scheme or arti-
22 fice—

23 “(1) to defraud any person or entity in connec-
24 tion with the delivery of or payment for health care
25 benefits, items, or services under a program under

1 title XVIII or a State health care program (as de-
2 fined in section 1128(h)), or

3 “(2) to obtain, by means of false or fraudulent
4 pretenses, representations, or promises, any of the
5 money or property owned by, or under the custody
6 or control of, any person or entity in connection with
7 the delivery of or payment for health care benefits,
8 items, or services under a program under title XVIII
9 or a State health care program, shall be fined under
10 title 18, United States Code, or imprisoned not more
11 than 10 years, or both. If the violation results in se-
12 rious bodily injury (as defined in section 1365(g)(3)
13 of title 18, United States Code), such person may be
14 imprisoned for any term of years.

15 “(b) FALSE STATEMENTS.—Whoever, in connection
16 with the delivery of or payment for health care benefits,
17 items, or services under a program under title XVIII or
18 a State health care program, knowingly and willfully—

19 “(1) falsifies, conceals, or covers up by any
20 trick, scheme, or device a material fact,

21 “(2) as to any material fact, makes any false,
22 fictitious, or fraudulent statements or representa-
23 tions, or

24 “(3) makes or uses any false writing or docu-
25 ment knowing the same to contain any false, ficti-

1 tious, or fraudulent statement or entry that is mate-
2 rial,

3 shall be fined under title 18, United States Code, or im-
4 prisoned not more than 5 years, or both.

5 “(c) THEFT OR EMBEZZLEMENT.—Whoever willfully
6 embezzles, steals, or otherwise without authority willfully
7 and unlawfully converts to the use of any person other
8 than the rightful owner, or intentionally misapplies any
9 of the moneys, funds, securities, premiums, credits, prop-
10 erty, or other assets of under the custody or control of
11 any person or entity in connection with the delivery of or
12 payment for health care benefits, items, or services under
13 program under title XVIII or a State health care program,
14 shall be fined under title 18, United States Code, or im-
15 prisoned not more than 10 years, or both.”.

16 (b) CONFORMING AMENDMENT.—Section 1128(h)
17 (42 U.S.C. 1320a–7(h)) is amended by striking “and
18 1128B” and inserting “, 1128B, and 1128C”.

19 **Subtitle C—Regulatory Relief**

20 **PART 1—PHYSICIAN OWNERSHIP REFERRAL**

21 **REFORM**

22 **SEC. 15201. REPEAL OF PROHIBITIONS BASED ON COM-** 23 **PENSATION ARRANGEMENTS.**

24 (a) IN GENERAL.—Section 1877(a)(2) (42 U.S.C.
25 1395nn(a)(2)) is amended by striking “is—” and all that

1 follows through “equity,” and inserting the following: “is
2 (except as provided in subsection (c)) an ownership or in-
3 vestment interest in the entity through equity,”.

4 (b) CONFORMING AMENDMENTS.—Section 1877 (42
5 U.S.C. 1395nn) is amended as follows:

6 (1) In subsection (b)—

7 (A) in the heading, by striking “TO BOTH
8 OWNERSHIP AND COMPENSATION ARRANGE-
9 MENT PROHIBITIONS” and inserting “WHERE
10 FINANCIAL RELATIONSHIP EXISTS”; and

11 (B) by redesignating paragraph (4) as
12 paragraph (7).

13 (2) In subsection (c)—

14 (A) by amending the heading to read as
15 follows: “EXCEPTION FOR OWNERSHIP OR IN-
16 VESTMENT INTEREST IN PUBLICLY TRADED
17 SECURITIES AND MUTUAL FUNDS”; and

18 (B) in the matter preceding paragraph (1),
19 by striking “subsection (a)(2)(A)” and inserting
20 “subsection (a)(2)”.

21 (3) In subsection (d)—

22 (A) by striking the matter preceding para-
23 graph (1);

24 (B) in paragraph (3), by striking “para-
25 graph (1)” and inserting “paragraph (4)”; and

1 (C) by redesignating paragraphs (1), (2),
2 and (3) as paragraphs (4), (5), and (6), and by
3 transferring and inserting such paragraphs
4 after paragraph (3) of subsection (b).

5 (4) By striking subsection (e).

6 (5) In subsection (f)(2)—

7 (A) in the matter preceding paragraph (1),
8 by striking “ownership, investment, and com-
9 pensation” and inserting “ownership and in-
10 vestment”;

11 (B) in paragraph (2), by striking “sub-
12 section (a)(2)(A)” and all that follows through
13 “subsection (a)(2)(B)),” and inserting “sub-
14 section (a)(2),”; and

15 (C) in paragraph (2), by striking “or who
16 have such a compensation relationship with the
17 entity”.

18 (6) In subsection (h)—

19 (A) by striking paragraphs (1), (2), and
20 (3);

21 (B) in paragraph (4)(A), by striking
22 clauses (iv) and (vi);

23 (C) in paragraph (4)(B), by striking
24 “RULES.—” and all that follows through “(ii)

1 FACULTY” and inserting “RULES FOR FAC-
2 ULTY”; and

3 (D) by adding at the end of paragraph (4)
4 the following new subparagraph:

5 “(C) MEMBER OF A GROUP.—A physician
6 is a ‘member’ of a group if the physician is an
7 owner or a bona fide employee, or both, of the
8 group.”.

9 **SEC. 15202. REVISION OF DESIGNATED HEALTH SERVICES**

10 **SUBJECT TO PROHIBITION.**

11 (a) IN GENERAL.—Section 1877(h)(6) (42 U.S.C.
12 1395nn(h)(6)) is amended by striking subparagraphs (B)
13 through (K) and inserting the following:

14 “(B) Parenteral and enteral nutrients,
15 equipment, and supplies.

16 “(C) Magnetic resonance imaging and
17 computerized tomography services.

18 “(D) Outpatient physical or occupational
19 therapy services.”.

20 (b) CONFORMING AMENDMENTS.—

21 (1) Section 1877(b)(2) (42 U.S.C.
22 1395nn(b)(2)) is amended in the matter preceding
23 subparagraph (A) by striking “services” and all that
24 follows through “supplies)—” and inserting “serv-
25 ices—”.

1 (2) Section 1877(h)(5)(C) (42 U.S.C.
2 1395nn(h)(5)(C)) is amended—

3 (A) by striking “, a request by a radiolo-
4 gist for diagnostic radiology services, and a re-
5 quest by a radiation oncologist for radiation
6 therapy,” and inserting “and a request by a ra-
7 diologist for magnetic resonance imaging or for
8 computerized tomography”, and

9 (B) by striking “radiologist, or radiation
10 oncologist” and inserting “or radiologist”.

11 **SEC. 15203. DELAY IN IMPLEMENTATION UNTIL PROMUL-**
12 **GATION OF REGULATIONS.**

13 (a) IN GENERAL.—Section 13562(b) of OBRA–1993
14 (42 U.S.C. 1395nn note) is amended—

15 (1) in paragraph (1), by striking “paragraph
16 (2)” and inserting “paragraphs (2) and (3)”; and

17 (2) by adding at the end the following new
18 paragraph:

19 “(3) PROMULGATION OF REGULATIONS.—Not-
20 withstanding paragraphs (1) and (2), the amend-
21 ments made by this section shall not apply to any
22 referrals made before the effective date of final regu-
23 lations promulgated by the Secretary of Health and
24 Human Services to carry out such amendments.”.

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall take effect as if included in the enact-
3 ment of OBRA–1993.

4 **SEC. 15204. EXCEPTIONS TO PROHIBITION.**

5 (a) REVISIONS TO EXCEPTION FOR IN-OFFICE AN-
6 CILLARY SERVICES.—

7 (1) REPEAL OF SITE-OF-SERVICE REQUIRE-
8 MENT.—Section 1877 (42 U.S.C. 1395nn) is amend-
9 ed—

10 (A) by amending subparagraph (A) of sub-
11 section (b)(2) to read as follows:

12 “(A) that are furnished personally by the
13 referring physician, personally by a physician
14 who is a member of the same group practice as
15 the referring physician, or personally by individ-
16 uals who are under the general supervision of
17 the physician or of another physician in the
18 group practice, and”, and

19 (B) by adding at the end of subsection (h)
20 the following new paragraph:

21 “(7) GENERAL SUPERVISION.—An individual is
22 considered to be under the ‘general supervision’ of a
23 physician if the physician (or group practice of
24 which the physician is a member) is legally respon-
25 sible for the services performed by the individual and

1 for ensuring that the individual meets licensure and
 2 certification requirements, if any, applicable under
 3 other provisions of law, regardless of whether or not
 4 the physician is physically present when the individ-
 5 ual furnishes an item or service.”.

6 (2) CLARIFICATION OF TREATMENT OF PHYSI-
 7 CIAN OWNERS OF GROUP PRACTICE.—Section
 8 1877(b)(2)(B) (42 U.S.C. 1395nn(b)(2)(B)) is
 9 amended by striking “physician or such group prac-
 10 tice” and inserting “physician, such group practice,
 11 or the physician owners of such group practice”.

12 (3) CONFORMING AMENDMENT.—Section
 13 1877(b)(2) (42 U.S.C. 1395nn(b)(2)) is amended by
 14 amending the heading to read as follows: “ANCIL-
 15 LARY SERVICES FURNISHED PERSONALLY OR
 16 THROUGH GROUP PRACTICE.—”.

17 (b) CLARIFICATION OF EXCEPTION FOR SERVICES
 18 FURNISHED IN A RURAL AREA.—Paragraph (5) of section
 19 1877(b) (42 U.S.C. 1395nn(b)), as transferred by section
 20 15201(b)(3)(C), is amended by striking “substantially all”
 21 and inserting “not less than 75 percent”.

22 (c) REVISION OF EXCEPTION FOR CERTAIN MAN-
 23 AGED CARE ARRANGEMENTS.—Section 1877(b)(3) (42
 24 U.S.C. 1395nn(b)(3)) is amended—

1 (1) in the heading by inserting “MANAGED
2 CARE ARRANGEMENTS” after “PREPAID PLANS”;

3 (2) in the matter preceding subparagraph (A),
4 by striking “organization—” and inserting “organi-
5 zation, directly or through contractual arrangements
6 with other entities, to individuals enrolled with the
7 organization—”;

8 (3) in subparagraph (A), by inserting “or part
9 C” after “section 1876”;

10 (4) by striking “or” at the end of subparagraph
11 (C);

12 (5) by striking the period at the end of sub-
13 paragraph (D) and inserting a comma; and

14 (6) by adding at the end the following new sub-
15 paragraphs:

16 “(E) with a contract with a State to pro-
17 vide services under the State plan under title
18 XIX (in accordance with section 1903(m)) or a
19 State MediGrant plan under title XXI; or

20 “(F) which is a MedicarePlus organization
21 under part C or which provides or arranges for
22 the provision of health care items or services
23 pursuant to a written agreement between the
24 organization and an individual or entity if the
25 written agreement places the individual or en-

1 tity at substantial financial risk for the cost or
2 utilization of the items or services which the in-
3 dividual or entity is obligated to provide, wheth-
4 er through a withhold, capitation, incentive
5 pool, per diem payment, or any other similar
6 risk arrangement which places the individual or
7 entity at substantial financial risk.”.

8 (d) NEW EXCEPTION FOR SHARED FACILITY SERV-
9 ICES.—

10 (1) IN GENERAL.—Section 1877(b) (42 U.S.C.
11 1395nn(b)), as amended by section 15201(b)(3)(C),
12 is amended—

13 (A) by redesignating paragraphs (4)
14 through (7) as paragraphs (5) through (8); and

15 (B) by inserting after paragraph (3) the
16 following new paragraph:

17 “(4) SHARED FACILITY SERVICES.—In the case
18 of a designated health service consisting of a shared
19 facility service of a shared facility—

20 “(A) that is furnished—

21 “(i) personally by the referring physi-
22 cian who is a shared facility physician or
23 personally by an individual directly em-
24 ployed or under the general supervision of
25 such a physician,

1 “(ii) by a shared facility in a building
2 in which the referring physician furnishes
3 substantially all of the services of the phy-
4 sician that are unrelated to the furnishing
5 of shared facility services, and

6 “(iii) to a patient of a shared facility
7 physician; and

8 “(B) that is billed by the referring physi-
9 cian or a group practice of which the physician
10 is a member.”.

11 (2) DEFINITIONS.—Section 1877(h) (42 U.S.C.
12 1395nn(h)), as amended by section 15201(b)(6), is
13 amended by inserting before paragraph (4) the fol-
14 lowing new paragraph:

15 “(1) SHARED FACILITY RELATED DEFINI-
16 TIONS.—

17 “(A) SHARED FACILITY SERVICE.—The
18 term ‘shared facility service’ means, with re-
19 spect to a shared facility, a designated health
20 service furnished by the facility to patients of
21 shared facility physicians.

22 “(B) SHARED FACILITY.—The term
23 ‘shared facility’ means an entity that furnishes
24 shared facility services under a shared facility
25 arrangement.

1 “(C) SHARED FACILITY PHYSICIAN.—The
2 term ‘shared facility physician’ means, with re-
3 spect to a shared facility, a physician (or a
4 group practice of which the physician is a mem-
5 ber) who has a financial relationship under a
6 shared facility arrangement with the facility.

7 “(D) SHARED FACILITY ARRANGEMENT.—
8 The term ‘shared facility arrangement’ means,
9 with respect to the provision of shared facility
10 services in a building, a financial arrange-
11 ment—

12 “(i) which is only between physicians
13 who are providing services (unrelated to
14 shared facility services) in the same build-
15 ing,

16 “(ii) in which the overhead expenses
17 of the facility are shared, in accordance
18 with methods previously determined by the
19 physicians in the arrangement, among the
20 physicians in the arrangement, and

21 “(iii) which, in the case of a corpora-
22 tion, is wholly owned and controlled by
23 shared facility physicians.”.

24 (e) NEW EXCEPTION FOR SERVICES FURNISHED IN
25 COMMUNITIES WITH NO ALTERNATIVE PROVIDERS.—

1 Section 1877(b) (42 U.S.C. 1395nn(b)), as amended by
2 section 15201(b)(3)(C) and subsection (d)(1), is amend-
3 ed—

4 (1) by redesignating paragraphs (5) through
5 (8) as paragraphs (6) through (9); and

6 (2) by inserting after paragraph (4) the follow-
7 ing new paragraph:

8 “(5) NO ALTERNATIVE PROVIDERS IN AREA.—

9 In the case of a designated health service furnished
10 in any area with respect to which the Secretary de-
11 termines that individuals residing in the area do not
12 have reasonable access to such a designated health
13 service for which subsection (a)(1) does not apply.”.

14 (f) NEW EXCEPTION FOR SERVICES FURNISHED IN
15 AMBULATORY SURGICAL CENTERS.—Section 1877(b) (42
16 U.S.C. 1395nn(b)), as amended by section
17 15201(b)(3)(C), subsection (d)(1), and subsection (e)(1),
18 is amended—

19 (1) by redesignating paragraphs (6) through
20 (9) as paragraphs (7) through (10); and

21 (2) by inserting after paragraph (5) the follow-
22 ing new paragraph:

23 “(6) SERVICES FURNISHED IN AMBULATORY
24 SURGICAL CENTERS.—In the case of a designated

1 health service furnished in an ambulatory surgical
2 center described in section 1832(a)(2)(F)(i).”.

3 (g) NEW EXCEPTION FOR SERVICES FURNISHED IN
4 RENAL DIALYSIS FACILITIES.—Section 1877(b) (42
5 U.S.C. 1395nn(b)), as amended by section
6 15201(b)(3)(C), subsection (d)(1), subsection (e)(1), and
7 subsection (f), is amended—

8 (1) by redesignating paragraphs (7) through
9 (10) as paragraphs (8) through (11); and

10 (2) by inserting after paragraph (6) the follow-
11 ing new paragraph:

12 “(7) SERVICES FURNISHED IN RENAL DIALYSIS
13 FACILITIES.—In the case of a designated health
14 service furnished in a renal dialysis facility under
15 section 1881.”.

16 (h) NEW EXCEPTION FOR SERVICES FURNISHED IN
17 A HOSPICE.—Section 1877(b) (42 U.S.C. 1395nn(b)), as
18 amended by section 15201(b)(3)(C), subsection (d)(1),
19 subsection (e)(1), subsection (f), and subsection (g), is
20 amended—

21 (1) by redesignating paragraphs (8) through
22 (11) as paragraphs (9) through (12); and

23 (2) by inserting after paragraph (7) the follow-
24 ing new paragraph:

1 “(8) SERVICES FURNISHED BY A HOSPICE PRO-
2 GRAM.—In the case of a designated health service
3 furnished by a hospice program under section
4 1861(dd)(2).”.

5 (i) NEW EXCEPTION FOR SERVICES FURNISHED IN
6 A COMPREHENSIVE OUTPATIENT REHABILITATION FA-
7 CILITY.—Section 1877(b) (42 U.S.C. 1395nn(b)), as
8 amended by section 15201(b)(3)(C), subsection (d)(1),
9 subsection (e)(1), subsection (f), subsection (g), and sub-
10 section (h), is amended—

11 (1) by redesignating paragraphs (9) through
12 (12) as paragraphs (10) through (13); and

13 (2) by inserting after paragraph (8) the follow-
14 ing new paragraph:

15 “(9) SERVICES FURNISHED IN A COMPREHEN-
16 SIVE OUTPATIENT REHABILITATION FACILITY.—In
17 the case of a designated health service furnished in
18 a comprehensive outpatient rehabilitation facility (as
19 defined in section 1861(cc)(2)).”.

20 (i) DEFINITION OF REFERRAL.—Section
21 1877(h)(5)(A) (42 U.S.C. 1395nn(h)(5)(A)) is amend-
22 ed—

23 (1) by striking “an item or service” and insert-
24 ing “a designated health service”, and

1 (2) by striking “the item or service” and insert-
2 ing “the designated health service”.

3 **SEC. 15205. REPEAL OF REPORTING REQUIREMENTS.**

4 Section 1877 (42 U.S.C. 1395nn) is amended—

5 (1) by striking subsection (f); and

6 (2) by striking subsection (g)(5).

7 **SEC. 15206. PREEMPTION OF STATE LAW.**

8 Section 1877 (42 U.S.C. 1395nn) is amended by add-
9 ing at the end the following new subsection:

10 “(i) PREEMPTION OF STATE LAW.—This section pre-
11 empts State law to the extent State law is inconsistent
12 with this section.”.

13 **SEC. 15207. EFFECTIVE DATE.**

14 Except as provided in section 15203(b), the amend-
15 ments made by this part shall apply to referrals made on
16 or after August 14, 1995, regardless of whether or not
17 regulations are promulgated to carry out such amend-
18 ments.

19 **PART 2—OTHER MEDICARE REGULATORY**
20 **RELIEF**

21 **SEC. 15211. REPEAL OF MEDICARE AND MEDICAID COV-**
22 **ERAGE DATA BANK.**

23 (a) IN GENERAL.—Section 1144 (42 U.S.C. 1320b-
24 14) is repealed.

25 (b) CONFORMING AMENDMENTS.—

1 (1) MEDICARE.—Section 1862(b)(5) (42 U.S.C.
2 1395y(b)(5)) is amended—

3 (A) in subparagraph (B), by striking
4 “under—” and all that follows through the end
5 and inserting “subparagraph (A) for purposes
6 of carrying out this subsection.”, and

7 (B) in subparagraph (C)(i), by striking
8 “subparagraph (B)(i)” and inserting “subpara-
9 graph (B)”.

10 (2) MEDICAID.—Section 1902(a)(25)(A)(i) (42
11 U.S.C. 1396a(a)(25)(A)(i)) is amended by striking
12 “including the use of” and all that follows through
13 “any additional measures”.

14 (3) ERISA.—Section 101(f) of the Employee
15 Retirement Income Security Act of 1974 (29 U.S.C.
16 1021(f)) is repealed.

17 (4) DATA MATCHES.—Section 552a(a)(8)(B) of
18 title 5, United States Code, is amended—

19 (A) by adding “; or” at the end of clause
20 (v),

21 (B) by striking “or” at the end of clause
22 (vi), and

23 (C) by striking clause (vii).

1 **SEC. 15212. CLARIFICATION OF LEVEL OF INTENT RE-**
 2 **QUIRED FOR IMPOSITION OF SANCTIONS.**

3 (a) CLARIFICATION OF LEVEL OF KNOWLEDGE RE-
 4 QUIRED FOR IMPOSITION OF CIVIL MONETARY PEN-
 5 ALTIES.—

6 (1) IN GENERAL.—Section 1128A(a) (42
 7 U.S.C. 1320a–7a(a)) is amended—

8 (A) in paragraphs (1) and (2), by inserting
 9 “knowingly” before “presents” each place it ap-
 10 pears; and

11 (B) in paragraph (3), by striking “gives”
 12 and inserting “knowingly gives or causes to be
 13 given”.

14 (2) DEFINITION OF STANDARD.—Section
 15 1128A(i) (42 U.S.C. 1320a–7a(i)) is amended by
 16 adding at the end the following new paragraph:

17 “(6) The term ‘should know’ means that a per-
 18 son, with respect to information—

19 “(A) acts in deliberate ignorance of the
 20 truth or falsity of the information; or

21 “(B) acts in reckless disregard of the truth
 22 or falsity of the information,
 23 and no proof of specific intent to defraud is re-
 24 quired.”.

25 (b) CLARIFICATION OF EFFECT AND APPLICATION
 26 OF SAFE HARBOR EXCEPTIONS.—For purposes of section

1 1128B(b)(3) of the Social Security Act, the specification
 2 of any payment practice in regulations promulgated pur-
 3 suant to section 14(a) of the Medicare and Medicaid Pro-
 4 gram and Patient Protection Act of 1987 is—

5 (1) solely for the purpose of adding additional
 6 exceptions to the types of conduct which are not
 7 subject to an anti-kickback penalty under such sec-
 8 tion and not for the purpose of limiting the scope of
 9 such exceptions; and

10 (2) for the purpose of prescribing criteria for
 11 qualifying for such an exception notwithstanding the
 12 intent of the party involved.

13 (c) LIMITING IMPOSITION OF ANTI-KICKBACK PEN-
 14 ALTIES TO ACTIONS WITH SIGNIFICANT PURPOSE TO IN-
 15 DUCE REFERRALS.—Section 1128B(b)(2) (42 U.S.C.
 16 1320a–7b(b)(2)) is amended in the matter preceding sub-
 17 paragraph (A) by striking “to induce” and inserting “for
 18 the significant purpose of inducing”.

19 (d) EFFECTIVE DATE.—The amendments made by
 20 this section shall apply to acts or omissions occurring on
 21 or after January 1, 1996.

1 **SEC. 15213. ADDITIONAL EXCEPTION TO ANTI-KICKBACK**
 2 **PENALTIES FOR MANAGED CARE ARRANGE-**
 3 **MENTS.**

4 (a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C.
 5 1320a–7b(b)(3)) is amended—

6 (1) by striking “and” at the end of subpara-
 7 graph (D);

8 (2) by striking the period at the end of sub-
 9 paragraph (E) and inserting “; and”; and

10 (3) by adding at the end the following new sub-
 11 paragraph:

12 “(F) any remuneration between an organization
 13 and an individual or entity providing services pursu-
 14 ant to a written agreement between the organization
 15 and the individual or entity if the organization is a
 16 MedicarePlus organization under part C of title
 17 XVIII or if the written agreement places the individ-
 18 ual or entity at substantial financial risk for the cost
 19 or utilization of the items or services which the indi-
 20 vidual or entity is obligated to provide, whether
 21 through a withhold, capitation, incentive pool, per
 22 diem payment, or any other similar risk arrange-
 23 ment which places the individual or entity at sub-
 24 stantial financial risk.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to acts or omissions occurring
3 on or after January 1, 1996.

4 **SEC. 15214. SOLICITATION AND PUBLICATION OF MODI-**
5 **FICATIONS TO EXISTING SAFE HARBORS AND**
6 **NEW SAFE HARBORS.**

7 (a) IN GENERAL.—

8 (1) SOLICITATIONS.—Not later than January 1,
9 1996, and not less than annually thereafter, the Sec-
10 retary of Health and Human Services shall publish
11 a notice in the Federal Register soliciting proposals,
12 which will be accepted during a 60-day period, for—

13 (A) modifications to existing safe harbors
14 issued pursuant to section 14(a) of the Medi-
15 care and Medicaid Patient and Program Protec-
16 tion Act of 1987;

17 (B) additional safe harbors specifying pay-
18 ment practices that shall not be treated as a
19 criminal offense under section 1128B(b) of the
20 Social Security Act and shall not serve as the
21 basis for an exclusion under section 1128(b)(7)
22 of such Act; and

23 (C) special fraud alerts to be issued pursu-
24 ant to section 15101(c).

1 (2) PUBLICATION OF PROPOSED MODIFICA-
 2 TIONS AND PROPOSED ADDITIONAL SAFE HAR-
 3 BORS.—Not later than 120 days after receiving the
 4 proposals described in subparagraphs (A) and (B) of
 5 paragraph (1), the Secretary, after considering such
 6 proposals in consultation with the Attorney General,
 7 shall publish in the Federal Register proposed modi-
 8 fications to existing safe harbors and proposed addi-
 9 tional safe harbors, if appropriate, with a 60-day
 10 comment period. After considering any public com-
 11 ments received during this period, the Secretary
 12 shall issue final rules modifying the existing safe
 13 harbors and establishing new safe harbors, as appro-
 14 priate.

15 (3) REPORT.—The Inspector General shall, in
 16 an annual report to Congress or as part of the year-
 17 end semiannual report required by section 5 of the
 18 Inspector General Act of 1978, describe the propos-
 19 als received under subparagraphs (A) and (B) of
 20 paragraph (1) and explain which proposals were in-
 21 cluded in the publication described in paragraph (2),
 22 which proposals were not included in that publica-
 23 tion, and the reasons for the rejection of the propos-
 24 als that were not included.

1 (b) CRITERIA FOR MODIFYING AND ESTABLISHING
 2 SAFE HARBORS.—In modifying and establishing safe har-
 3 bors under subsection (a)(2), the Secretary may consider
 4 the extent to which providing a safe harbor for the speci-
 5 fied payment practice may result in any of the following:

6 (1) An increase or decrease in access to health
 7 care services.

8 (2) An increase or decrease in the quality of
 9 health care services.

10 (3) An increase or decrease in patient freedom
 11 of choice among health care providers.

12 (4) An increase or decrease in competition
 13 among health care providers.

14 (5) An increase or decrease in the cost to health
 15 care programs of the Federal Government.

16 (6) An increase or decrease in the potential
 17 overutilization of health care services.

18 (7) Any other factors the Secretary deems ap-
 19 propriate in the interest of preventing fraud and
 20 abuse in health care programs of the Federal Gov-
 21 ernment.

1 **SEC. 15215. ISSUANCE OF ADVISORY OPINIONS UNDER**
 2 **TITLE XI.**

3 (a) IN GENERAL.—Title XI (42 U.S.C. 1301 et seq.),
 4 as amended by section 15104(a), is amended by inserting
 5 after section 1129 the following new section:

6 “ADVISORY OPINIONS

7 “SEC. 1130. (a) ISSUANCE OF ADVISORY OPIN-
 8 IONS.—The Secretary shall issue written advisory opinions
 9 as provided in this section.

10 “(b) MATTERS SUBJECT TO ADVISORY OPINIONS.—
 11 The Secretary shall issue advisory opinions as to the fol-
 12 lowing matters:

13 “(1) What constitutes prohibited remuneration
 14 within the meaning of section 1128B(b).

15 “(2) Whether an arrangement or proposed ar-
 16 rangement satisfies the criteria set forth in section
 17 1128B(b)(3) for activities which do not result in
 18 prohibited remuneration.

19 “(3) Whether an arrangement or proposed ar-
 20 rangement satisfies the criteria which the Secretary
 21 has established, or shall establish by regulation for
 22 activities which do not result in prohibited remu-
 23 nation.

24 “(4) What constitutes an inducement to reduce
 25 or limit services to individuals entitled to benefits

1 under title XVIII or title XIX or title XXI within
2 the meaning of section 1128B(b).

3 “(5) Whether any activity or proposed activity
4 constitutes grounds for the imposition of a sanction
5 under section 1128, 1128A, or 1128B.

6 “(c) MATTERS NOT SUBJECT TO ADVISORY OPIN-
7 IONS.—Such advisory opinions shall not address the fol-
8 lowing matters:

9 “(1) Whether the fair market value shall be, or
10 was paid or received for any goods, services or prop-
11 erty.

12 “(2) Whether an individual is a bona fide em-
13 ployee within the requirements of section 3121(d)(2)
14 of the Internal Revenue Code of 1986.

15 “(d) EFFECT OF ADVISORY OPINIONS.—

16 “(1) BINDING AS TO SECRETARY AND PARTIES
17 INVOLVED.—Each advisory opinion issued by the
18 Secretary shall be binding as to the Secretary and
19 the party or parties requesting the opinion.

20 “(2) FAILURE TO SEEK OPINION.—The failure
21 of a party to seek an advisory opinion may not be
22 introduced into evidence to prove that the party in-
23 tended to violate the provisions of sections 1128,
24 1128A, or 1128B.

25 “(e) REGULATIONS.—

1 “(1) IN GENERAL.—Not later than 180 days
2 after the date of the enactment of this section, the
3 Secretary shall issue regulations to carry out this
4 section. Such regulations shall provide for—

5 “(A) the procedure to be followed by a
6 party applying for an advisory opinion;

7 “(B) the procedure to be followed by the
8 Secretary in responding to a request for an ad-
9 visory opinion;

10 “(C) the interval in which the Secretary
11 shall respond;

12 “(D) the reasonable fee to be charged to
13 the party requesting an advisory opinion; and

14 “(E) the manner in which advisory opin-
15 ions will be made available to the public.

16 “(2) SPECIFIC CONTENTS.—Under the regula-
17 tions promulgated pursuant to paragraph (1)—

18 “(A) the Secretary shall be required to re-
19 spond to a party requesting an advisory opinion
20 by not later than 30 days after the request is
21 received; and

22 “(B) the fee charged to the party request-
23 ing an advisory opinion shall be equal to the
24 costs incurred by the Secretary in responding to
25 the request.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to requests for advisory opinions
3 made on or after January 1, 1996.

4 **SEC. 15216. PRIOR NOTICE OF CHANGES IN BILLING AND**
5 **CLAIMS PROCESSING REQUIREMENTS FOR**
6 **PHYSICIANS' SERVICES.**

7 Except as may be specifically provided by Congress,
8 the Secretary of Health and Human Services may not im-
9 plement any change in the requirements imposed on the
10 billing and processing of claims for payment for physi-
11 cians' services under part B of the medicare program un-
12 less the Secretary notifies the individuals furnishing such
13 services of the change not later than 120 days before the
14 effective date of the change.

15 **PART 3—PROMOTING PHYSICIAN SELF-POLICING**
16 **SEC. 15221. EXEMPTION FROM ANTITRUST LAWS FOR CER-**
17 **TAIN ACTIVITIES OF MEDICAL SELF-REGU-**
18 **LATORY ENTITIES.**

19 (a) EXEMPTION DESCRIBED.—An activity relating to
20 the provision of health care services shall be exempt from
21 the antitrust laws, and any State law similar to the anti-
22 trust laws, if the activity is within the safe harbor de-
23 scribed in subsection (b).

24 (b) SAFE HARBOR FOR ACTIVITIES OF MEDICAL
25 SELF-REGULATORY ENTITIES.—

1 (1) IN GENERAL.—The safe harbor referred to
2 in subsection (a) is, subject to paragraph (2), any
3 activity of a medical self-regulatory entity relating to
4 standard setting or standard enforcement activities
5 that are designed to promote the quality of health
6 care services provided to patients.

7 (2) EXCEPTION.—No activity of a medical self-
8 regulatory entity may be deemed to fall under the
9 safe harbor established under paragraph (1) if the
10 activity—

11 (A) is conducted for purposes of financial
12 gain, or

13 (B) interferes with the provision of health
14 care services by any health care provider who is
15 not a member of the specific profession which
16 is subject to the authority of the medical self-
17 regulatory entity.

18 (c) DEFINITIONS.—For purposes of this section:

19 (1) ANTITRUST LAWS.—The term “antitrust
20 laws” has the meaning given it in subsection (a) of
21 the first section of the Clayton Act (15 U.S.C.
22 12(a)), except that such term includes section 5 of
23 the Federal Trade Commission Act (15 U.S.C. 45)
24 to the extent such section applies to unfair methods
25 of competition.

1 (2) HEALTH BENEFIT PLAN.—The term
2 “health benefit plan” means—

3 (A) a hospital or medical expense incurred
4 policy or certificate,

5 (B) a hospital or medical service plan con-
6 tract,

7 (C) a health maintenance subscriber con-
8 tract,

9 (D) a multiple employer welfare arrange-
10 ment or employee benefit plan (as defined
11 under the Employee Retirement Income Secu-
12 rity Act of 1974), or

13 (E) a MedicarePlus product (offered under
14 part C of title XVIII of the Social Security
15 Act),

16 that provides benefits with respect to health care
17 services.

18 (3) HEALTH CARE SERVICE.—The term “health
19 care service” means any service for which payment
20 may be made under a health benefit plan including
21 services related to the delivery or administration of
22 such service.

23 (4) MEDICAL SELF-REGULATORY ENTITY.—The
24 term “medical self-regulatory entity” means a medi-
25 cal society or association, a specialty board, a recog-

nized accrediting agency, or a hospital medical staff, and includes the members, officers, employees, consultants, and volunteers or committees of such an entity.

(5) HEALTH CARE PROVIDER.—The term “health care provider” means any individual or entity that is engaged in the delivery of health care services in a State and that is required by State law or regulation to be licensed or certified by the State to engage in the delivery of such services in the State.

(6) STANDARD SETTING OR STANDARD ENFORCEMENT ACTIVITIES.—The term “standard setting or standard enforcement activities” means—

(A) accreditation of health care practitioners, health care providers, medical education institutions, or medical education programs,

(B) technology assessment and risk management activities,

(C) the development and implementation of practice guidelines or practice parameters, or

(D) official peer review proceedings undertaken by a hospital medical staff (or committee thereof) or a medical society or association for purposes of evaluating the professional conduct

1 or quality of health care provided by a medical
2 professional.

3 **Subtitle D—Medical Liability** 4 **Reform**

5 **PART 1—GENERAL PROVISIONS**

6 **SEC. 15301. FEDERAL REFORM OF HEALTH CARE LIABILITY** 7 **ACTIONS.**

8 (a) **APPLICABILITY.**—This subtitle shall apply with
9 respect to any health care liability action brought in any
10 State or Federal court, except that this subtitle shall not
11 apply to—

12 (1) an action for damages arising from a vac-
13 cine-related injury or death to the extent that title
14 XXI of the Public Health Service Act applies to the
15 action, or

16 (2) an action under the Employee Retirement
17 Income Security Act of 1974 (29 U.S.C. 1001 et
18 seq.).

19 (b) **PREEMPTION.**—This subtitle shall preempt any
20 State law to the extent such law is inconsistent with the
21 limitations contained in this subtitle. This subtitle shall
22 not preempt any State law that provides for defenses or
23 places limitations on a person’s liability in addition to
24 those contained in this subtitle or otherwise imposes great-
25 er restrictions than those provided in this subtitle.

1 (c) EFFECT ON SOVEREIGN IMMUNITY AND CHOICE
2 OF LAW OR VENUE.—Nothing in subsection (b) shall be
3 construed to—

4 (1) waive or affect any defense of sovereign im-
5 munity asserted by any State under any provision of
6 law;

7 (2) waive or affect any defense of sovereign im-
8 munity asserted by the United States;

9 (3) affect the applicability of any provision of
10 the Foreign Sovereign Immunities Act of 1976;

11 (4) preempt State choice-of-law rules with re-
12 spect to claims brought by a foreign nation or a citi-
13 zen of a foreign nation; or

14 (5) affect the right of any court to transfer
15 venue or to apply the law of a foreign nation or to
16 dismiss a claim of a foreign nation or of a citizen
17 of a foreign nation on the ground of inconvenient
18 forum.

19 (d) AMOUNT IN CONTROVERSY.—In an action to
20 which this subtitle applies and which is brought under sec-
21 tion 1332 of title 28, United States Code, the amount of
22 noneconomic damages or punitive damages, and attorneys'
23 fees or costs, shall not be included in determining whether
24 the matter in controversy exceeds the sum or value of
25 \$50,000.

1 (e) FEDERAL COURT JURISDICTION NOT ESTAB-
 2 LISHED ON FEDERAL QUESTION GROUNDS.—Nothing in
 3 this subtitle shall be construed to establish any jurisdiction
 4 in the district courts of the United States over health care
 5 liability actions on the basis of section 1331 or 1337 of
 6 title 28, United States Code.

7 **SEC. 15302. DEFINITIONS.**

8 As used in this subtitle:

9 (1) ACTUAL DAMAGES.—The term “actual dam-
 10 ages” means damages awarded to pay for economic
 11 loss.

12 (2) ALTERNATIVE DISPUTE RESOLUTION SYS-
 13 TEM; ADR.—The term “alternative dispute resolution
 14 system” or “ADR” means a system established
 15 under Federal or State law that provides for the res-
 16 olution of health care liability claims in a manner
 17 other than through health care liability actions.

18 (3) CLAIMANT.—The term “claimant” means
 19 any person who brings a health care liability action
 20 and any person on whose behalf such an action is
 21 brought. If such action is brought through or on be-
 22 half of an estate, the term includes the claimant’s
 23 decedent. If such action is brought through or on be-
 24 half of a minor or incompetent, the term includes
 25 the claimant’s legal guardian.

1 (4) CLEAR AND CONVINCING EVIDENCE.—The
 2 term “clear and convincing evidence” is that meas-
 3 ure or degree of proof that will produce in the mind
 4 of the trier of fact a firm belief or conviction as to
 5 the truth of the allegations sought to be established.
 6 Such measure or degree of proof is more than that
 7 required under preponderance of the evidence but
 8 less than that required for proof beyond a reason-
 9 able doubt.

10 (5) COLLATERAL SOURCE PAYMENTS.—The
 11 term “collateral source payments” means any
 12 amount paid or reasonably likely to be paid in the
 13 future to or on behalf of a claimant, or any service,
 14 product, or other benefit provided or reasonably like-
 15 ly to be provided in the future to or on behalf of a
 16 claimant, as a result of an injury or wrongful death,
 17 pursuant to—

18 (A) any State or Federal health, sickness,
 19 income-disability, accident or workers’ com-
 20 pensation Act;

21 (B) any health, sickness, income-disability,
 22 or accident insurance that provides health bene-
 23 fits or income-disability coverage;

24 (C) any contract or agreement of any
 25 group, organization, partnership, or corporation

1 to provide, pay for, or reimburse the cost of
2 medical, hospital, dental, or income disability
3 benefits; and

4 (D) any other publicly or privately funded
5 program.

6 (6) DRUG.—The term “drug” has the meaning
7 given such term in section 201(g)(1) of the Federal
8 Food, Drug, and Cosmetic Act (21 U.S.C.
9 321(g)(1)).

10 (7) ECONOMIC LOSS.—The term “economic
11 loss” means any pecuniary loss resulting from injury
12 (including the loss of earnings or other benefits re-
13 lated to employment, medical expense loss, replace-
14 ment services loss, loss due to death, burial costs,
15 and loss of business or employment opportunities),
16 to the extent recovery for such loss is allowed under
17 applicable State law.

18 (8) HARM.—The term “harm” means any le-
19 gally cognizable wrong or injury for which punitive
20 damages may be imposed.

21 (9) HEALTH BENEFIT PLAN.—The term
22 “health benefit plan” means—

23 (A) a hospital or medical expense incurred
24 policy or certificate,

1 (B) a hospital or medical service plan con-
2 tract,

3 (C) a health maintenance subscriber con-
4 tract, or

5 (D) a MedicarePlus product (offered under
6 part C of title XVIII of the Social Security
7 Act),

8 that provides benefits with respect to health care
9 services.

10 (10) HEALTH CARE LIABILITY ACTION.—The
11 term “health care liability action” means a civil ac-
12 tion brought in a State or Federal court against a
13 health care provider, an entity which is obligated to
14 provide or pay for health benefits under any health
15 benefit plan (including any person or entity acting
16 under a contract or arrangement to provide or ad-
17 minister any health benefit), or the manufacturer,
18 distributor, supplier, marketer, promoter, or seller of
19 a medical product, in which the claimant alleges a
20 claim (including third party claims, cross claims,
21 counter claims, or distribution claims) based upon
22 the provision of (or the failure to provide or pay for)
23 health care services or the use of a medical product,
24 regardless of the theory of liability on which the

1 claim is based on the number of plaintiffs, defend-
2 ants, or causes of action.

3 (11) HEALTH CARE LIABILITY CLAIM.—The
4 term “health care liability claim” means a claim in
5 which the claimant alleges that injury was caused by
6 the provision of (or the failure to provide) health
7 care services.

8 (12) HEALTH CARE PROVIDER.—The term
9 “health care provider” means any person that is en-
10 gaged in the delivery of health care services in a
11 State and that is required by the laws or regulations
12 of the State to be licensed or certified by the State
13 to engage in the delivery of such services in the
14 State.

15 (13) HEALTH CARE SERVICE.—The term
16 “health care service” means any service for which
17 payment may be made under a health benefit plan
18 including services related to the delivery or adminis-
19 tration of such service.

20 (14) MEDICAL DEVICE.—The term “medical de-
21 vice” has the meaning given such term in section
22 201(h) of the Federal Food, Drug, and Cosmetic
23 Act (21 U.S.C. 321(h)).

24 (15) NONECONOMIC DAMAGES.—The term
25 “noneconomic damages” means damages paid to an

1 individual for pain and suffering, inconvenience,
2 emotional distress, mental anguish, loss of consor-
3 tium, injury to reputation, humiliation, and other
4 nonpecuniary losses.

5 (16) PERSON.—The term “person” means any
6 individual, corporation, company, association, firm,
7 partnership, society, joint stock company, or any
8 other entity, including any governmental entity.

9 (17) PRODUCT SELLER.—

10 (A) IN GENERAL.—Subject to subpara-
11 graph (B), the term “product seller” means a
12 person who, in the course of a business con-
13 ducted for that purpose—

14 (i) sells, distributes, rents, leases, pre-
15 pares, blends, packages, labels, or is other-
16 wise involved in placing, a product in the
17 stream of commerce, or

18 (ii) installs, repairs, or maintains the
19 harm-causing aspect of a product.

20 (B) EXCLUSION.—Such term does not in-
21 clude—

22 (i) a seller or lessor of real property;

23 (ii) a provider of professional services
24 in any case in which the sale or use of a
25 product is incidental to the transaction and

1 the essence of the transaction is the fur-
 2 nishing of judgment, skill, or services; or

3 (iii) any person who—

4 (I) acts in only a financial capac-
 5 ity with respect to the sale of a prod-
 6 uct; or

7 (II) leases a product under a
 8 lease arrangement in which the selec-
 9 tion, possession, maintenance, and op-
 10 eration of the product are controlled
 11 by a person other than the lessor.

12 (18) PUNITIVE DAMAGES.—The term “punitive
 13 damages” means damages awarded against any per-
 14 son not to compensate for actual injury suffered, but
 15 to punish or deter such person or others from en-
 16 gaging in similar behavior in the future.

17 (19) STATE.—The term “State” means each of
 18 the several States, the District of Columbia, Puerto
 19 Rico, the Virgin Islands, Guam, American Samoa,
 20 the Northern Mariana Islands, and any other terri-
 21 tory or possession of the United States.

22 **SEC. 15303. EFFECTIVE DATE.**

23 This subtitle will apply to any health care liability ac-
 24 tion brought in a Federal or State court and to any health
 25 care liability claim subject to an alternative dispute resolu-

tion system, that is initiated on or after the date of enactment of this subtitle, except that any health care liability claim or action arising from an injury occurring prior to the date of enactment of this subtitle shall be governed by the applicable statute of limitations provisions in effect at the time the injury occurred.

PART 2—UNIFORM STANDARDS FOR HEALTH CARE LIABILITY ACTIONS

SEC. 15311. STATUTE OF LIMITATIONS.

A health care liability action may not be brought after the expiration of the 2-year period that begins on the date on which the alleged injury that is the subject of the action was discovered or should reasonably have been discovered, but in no case after the expiration of the 5-year period that begins on the date the alleged injury occurred.

SEC. 15312. CALCULATION AND PAYMENT OF DAMAGES.

(a) TREATMENT OF NONECONOMIC DAMAGES.—

(1) LIMITATION ON NONECONOMIC DAMAGES.—

The total amount of noneconomic damages that may be awarded to a claimant for losses resulting from the injury which is the subject of a health care liability action may not exceed \$250,000, regardless of the number of parties against whom the action is

1 brought or the number of actions brought with re-
2 spect to the injury.

3 (2) JOINT AND SEVERAL LIABILITY.—In any
4 health care liability action brought in State or Fed-
5 eral court, a defendant shall be liable only for the
6 amount of noneconomic damages attributable to
7 such defendant in direct proportion to such defend-
8 ant’s share of fault or responsibility for the claim-
9 ant’s actual damages, as determined by the trier of
10 fact. In all such cases, the liability of a defendant
11 for noneconomic damages shall be several and not
12 joint.

13 (b) TREATMENT OF PUNITIVE DAMAGES.—

14 (1) GENERAL RULE.—Punitive damages may,
15 to the extent permitted by applicable State law, be
16 awarded in any health care liability action for harm
17 in any Federal or State court against a defendant if
18 the claimant establishes by clear and convincing evi-
19 dence that the harm suffered was the result of con-
20 duct—

21 (A) specifically intended to cause harm, or

22 (B) conduct manifesting a conscious, fla-
23 grant indifference to the rights or safety of oth-
24 ers.

1 (2) PROPORTIONAL AWARDS.—The amount of
2 punitive damages that may be awarded in any health
3 care liability action subject to this subtitle shall not
4 exceed 3 times the amount of damages awarded to
5 the claimant for economic loss, or \$250,000, which-
6 ever is greater. This paragraph shall be applied by
7 the court and shall not be disclosed to the jury.

8 (3) APPLICABILITY.—This subsection shall
9 apply to any health care liability action brought in
10 any Federal or State court on any theory where pu-
11 nitive damages are sought. This subsection does not
12 create a cause of action for punitive damages. This
13 subsection does not preempt or supersede any State
14 or Federal law to the extent that such law would
15 further limit the award of punitive damages.

16 (4) BIFURCATION.—At the request of any
17 party, the trier of fact shall consider in a separate
18 proceeding whether punitive damages are to be
19 awarded and the amount of such award. If a sepa-
20 rate proceeding is requested, evidence relevant only
21 to the claim of punitive damages, as determined by
22 applicable State law, shall be inadmissible in any
23 proceeding to determine whether actual damages are
24 to be awarded.

25 (5) DRUGS AND DEVICES.—

1 (A) IN GENERAL.—(i) Punitive damages
2 shall not be awarded against a manufacturer or
3 product seller of a drug or medical device which
4 caused the claimant’s harm where—

5 (I) such drug or device was subject to
6 premarket approval by the Food and Drug
7 Administration with respect to the safety
8 of the formulation or performance of the
9 aspect of such drug or device which caused
10 the claimant’s harm, or the adequacy of
11 the packaging or labeling of such drug or
12 device which caused the harm, and such
13 drug, device, packaging, or labeling was
14 approved by the Food and Drug Adminis-
15 tration; or

16 (II) the drug is generally recognized
17 as safe and effective pursuant to conditions
18 established by the Food and Drug Admin-
19 istration and applicable regulations, includ-
20 ing packaging and labeling regulations.

21 (ii) Clause (i) shall not apply in any case
22 in which the defendant, before or after pre-
23 market approval of a drug or device—

24 (I) intentionally and wrongfully with-
25 held from or misrepresented to the Food

and Drug Administration information concerning such drug or device required to be submitted under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.) or section 351 of the Public Health Service Act (42 U.S.C. 262) that is material and relevant to the harm suffered by the claimant, or

(II) made an illegal payment to an official or employee of the Food and Drug Administration for the purpose of securing or maintaining approval of such drug or device.

(B) PACKAGING.—In a health care liability action for harm which is alleged to relate to the adequacy of the packaging or labeling of a drug which is required to have tamper-resistant packaging under regulations of the Secretary of Health and Human Services (including labeling regulations related to such packaging), the manufacturer or product seller of the drug shall not be held liable for punitive damages unless such packaging or labeling is found by the court by clear and convincing evidence to be substantially out of compliance with such regulations.

1 (c) PERIODIC PAYMENTS FOR FUTURE LOSSES.—

2 (1) GENERAL RULE.—In any health care liabil-
 3 ity action in which the damages awarded for future
 4 economic and noneconomic loss exceeds \$50,000, a
 5 person shall not be required to pay such damages in
 6 a single, lump-sum payment, but shall be permitted
 7 to make such payments periodically based on when
 8 the damages are found likely to occur, as such pay-
 9 ments are determined by the court.

10 (2) FINALITY OF JUDGMENT.—The judgment
 11 of the court awarding periodic payments under this
 12 subsection may not, in the absence of fraud, be re-
 13 opened at any time to contest, amend, or modify the
 14 schedule or amount of the payments.

15 (3) LUMP-SUM SETTLEMENTS.—This sub-
 16 section shall not be construed to preclude a settle-
 17 ment providing for a single, lump-sum payment.

18 (d) TREATMENT OF COLLATERAL SOURCE PAY-
 19 MENTS.—

20 (1) INTRODUCTION INTO EVIDENCE.—In any
 21 health care liability action, any defendant may intro-
 22 duce evidence of collateral source payments. If any
 23 defendant elects to introduce such evidence, the
 24 claimant may introduce evidence of any amount paid
 25 or contributed or reasonably likely to be paid or con-

1 tributed in the future by or on behalf of the claim-
2 ant to secure the right to such collateral source pay-
3 ments.

4 (2) NO SUBROGATION.—No provider of collat-
5 eral source payments shall recover any amount
6 against the claimant or receive any lien or credit
7 against the claimant's recovery or be equitably or le-
8 gally subrogated the right of the claimant in a
9 health care liability action.

10 (3) APPLICATION TO SETTLEMENTS.—This sub-
11 section shall apply to an action that is settled as well
12 as an action that is resolved by a fact finder.

13 **SEC. 15313. ALTERNATIVE DISPUTE RESOLUTION.**

14 Any ADR used to resolve a health care liability action
15 or claim shall contain provisions relating to statute of limi-
16 tations, non-economic damages, joint and several liability,
17 punitive damages, collateral source rule, and periodic pay-
18 ments which are identical to the provisions relating to
19 such matters in this subtitle.

1 **Subtitle E—Teaching Hospitals and**
 2 **Graduate Medical Education**

3 **PART 1—TEACHING HOSPITAL AND GRADUATE**
 4 **MEDICAL EDUCATION TRUST FUND**

5 **SEC. 15401. ESTABLISHMENT OF FUND; PAYMENTS TO**
 6 **TEACHING HOSPITALS.**

7 The Social Security Act (42 U.S.C. 300 et seq.) is
 8 amended by adding after title XXI the following title:

9 “TITLE XXII—TEACHING HOSPITAL AND
 10 GRADUATE MEDICAL EDUCATION TRUST FUND

11 “PART A—ESTABLISHMENT OF FUND

12 **“SEC. 2201. ESTABLISHMENT OF FUND.**

13 “(a) IN GENERAL.—There is established in the
 14 Treasury of the United States a fund to be known as the
 15 Teaching Hospital and Graduate Medical Education Trust
 16 Fund (in this title referred to as the ‘Fund’), consisting
 17 of amounts appropriated to the Fund in subsection (d)
 18 and subsection (e)(3), amounts transferred to the Fund
 19 under section 1886(j), and such gifts and bequests as may
 20 be deposited in the Fund pursuant to subsection (f).
 21 Amounts in the Fund are available until expended.

22 “(b) EXPENDITURES FROM FUND.—Amounts in the
 23 Fund are available to the Secretary for making payments
 24 under section 2211.

1 “(c) ACCOUNTS IN FUND.—There are established
2 within the Fund the following accounts:

3 “(1) The Indirect-Costs Medical Education Ac-
4 count.

5 “(2) The Medicare Direct-Costs Medical Edu-
6 cation Account.

7 “(3) The General Direct-Costs Medical Edu-
8 cation Account.

9 “(d) GENERAL TRANSFERS TO FUND.—

10 “(1) IN GENERAL.—For fiscal year 1997 and
11 each subsequent fiscal year, there are appropriated
12 to the Fund (effective on the applicable date under
13 paragraph (2)), out of any money in the Treasury
14 not otherwise appropriated, the following amounts
15 (as applicable to the fiscal year involved):

16 “(A) For fiscal year 1997,
17 \$1,300,000,000.

18 “(B) For fiscal year 1998,
19 \$1,500,000,000.

20 “(C) For fiscal year 1999, \$2,300,000,000.

21 “(D) For fiscal year 2000,
22 \$3,100,000,000.

23 “(E) For fiscal year 2001,
24 \$3,600,000,000.

1 “(F) For fiscal year 2002,
2 \$4,000,000,000.

3 “(G) For fiscal year 2003 and each subse-
4 quent fiscal year, the greater of the amount ap-
5 propriated for the preceding fiscal year or an
6 amount equal to the product of—

7 “(i) the amount appropriated for the
8 preceding fiscal year; and

9 “(ii) 1 plus the percentage increase in
10 the nominal gross domestic product for the
11 one-year period ending upon July 1 of such
12 preceding fiscal year.

13 “(2) EFFECTIVE DATE FOR ANNUAL APPRO-
14 PRIATION.—For purposes of paragraph (1) (and for
15 purposes of section 2221(a)(1), and subsections
16 (b)(1)(A) and (c)(1)(A) of section 2231)), the appli-
17 cable date for a fiscal year is the first day of the fis-
18 cal year, exclusive of Saturdays, Sundays, and Fed-
19 eral holidays.

20 “(3) ALLOCATION AMONG CERTAIN AC-
21 COUNTS.—Of the amount appropriated in paragraph
22 (1) for a fiscal year—

23 “(A) there shall be allocated to the Indi-
24 rect-Costs Medical Education Account the per-

1 centage determined under paragraph (4)(B);
2 and

3 “(B) there shall be allocated to the Gen-
4 eral Direct-Costs Medical Education Account
5 the percentage determined under paragraph
6 (4)(C).

7 “(4) DETERMINATION OF PERCENTAGES.—The
8 Secretary of Health and Human Services, acting
9 through the Administrator of the Health Care Fi-
10 nancing Administration, shall determine the follow-
11 ing:

12 “(A) The total amount of payments that
13 were made under subsections (d)(5)(B) and (h)
14 of section 1886 for fiscal year 1994.

15 “(B) The percentage of such total that was
16 constituted by payments under subsection
17 (d)(5)(B) of such section.

18 “(C) The percentage of such total that was
19 constituted by payments under subsection (h) of
20 such section.

21 “(e) INVESTMENT.—

22 “(1) IN GENERAL.—The Secretary of the
23 Treasury shall invest such amounts of the Fund as
24 such Secretary determines are not required to meet
25 current withdrawals from the Fund. Such invest-

1 ments may be made only in interest-bearing obliga-
2 tions of the United States. For such purpose, such
3 obligations may be acquired on original issue at the
4 issue price, or by purchase of outstanding obliga-
5 tions at the market price.

6 “(2) SALE OF OBLIGATIONS.—Any obligation
7 acquired by the Fund may be sold by the Secretary
8 of the Treasury at the market price.

9 “(3) AVAILABILITY OF INCOME.—Any interest
10 derived from obligations acquired by the Fund, and
11 proceeds from any sale or redemption of such obliga-
12 tions, are hereby appropriated to the Fund.

13 “(f) ACCEPTANCE OF GIFTS AND BEQUESTS.—The
14 Fund may accept on behalf of the United States money
15 gifts and bequests made unconditionally to the Fund for
16 the benefit of the Fund or any activity financed through
17 the Fund.

18 “PART B—PAYMENTS TO TEACHING HOSPITALS

19 “Subpart 1—Requirement of Payments

20 **“SEC. 2211. FORMULA PAYMENTS TO TEACHING HOS-**
21 **PITALS.**

22 “(a) IN GENERAL.—Subject to subsection (d), in the
23 case of each teaching hospital that in accordance with sub-
24 section (b) submits to the Secretary a payment document
25 for fiscal year 1997 or any subsequent fiscal year, the Sec-

1 retary shall make payments for the year to the teaching
 2 hospital for the costs of operating approved medical resi-
 3 dency training programs. Such payments shall be made
 4 from the Fund, and the total of the payments to the hos-
 5 pital for the fiscal year shall equal the sum of the follow-
 6 ing:

7 “(1) An amount determined under section 2221
 8 (relating to the indirect costs of graduate medical
 9 education).

10 “(2) An amount determined under section 2231
 11 (relating to the direct costs of graduate medical edu-
 12 cation).

13 “(b) PAYMENT DOCUMENT.—For purposes of sub-
 14 section (a), a payment document is a document containing
 15 such information as may be necessary for the Secretary
 16 to make payments under such subsection to a teaching
 17 hospital for a fiscal year. The document is submitted in
 18 accordance with this subsection if the document is submit-
 19 ted not later than the date specified by the Secretary, and
 20 the document is in such form and is made in such manner
 21 as the Secretary may require. The Secretary may require
 22 that information under this subsection be submitted to the
 23 Secretary in periodic reports.

24 “(c) ADMINISTRATOR OF PROGRAMS.—This part,
 25 and the subsequent parts of this title, shall be carried out

1 by the Secretary acting through the Administrator of the
2 Health Care Financing Administration.

3 “(d) SPECIAL RULES.—

4 “(1) AUTHORITY REGARDING PAYMENTS TO
5 CONSORTIA OF PROVIDERS.—In the case of pay-
6 ments under subsection (a) that are determined
7 under section 2231:

8 “(A) The requirement under such sub-
9 section to make the payments to teaching hos-
10 pitals is subject to the authority of the Sec-
11 retary under section 2233(a) to make payments
12 to qualifying consortia.

13 “(B) If the Secretary authorizes such a
14 consortium for purposes of section 2233(a),
15 subsections (a) and (b) of this section apply to
16 the consortium to the same extent and in the
17 same manner as the subsections apply to teach-
18 ing hospitals.

19 “(2) CERTAIN HOSPITALS.—Paragraph (1) of
20 subsection (a) is subject to sections 2222 and 2223
21 of subpart 2. Paragraph (2) of subsection (a) is sub-
22 ject to sections 2232 through 2234 of subpart 3.

23 “(e) APPROVED MEDICAL RESIDENCY TRAINING
24 PROGRAM.—For purposes of this title, the term ‘approved

1 medical residency training program’ has the meaning
2 given such term in section 1886(h)(5)(A).

3 “Subpart 2—Amount Relating to Indirect Costs of
4 Graduate Medical Education

5 **“SEC. 2221. DETERMINATION OF AMOUNT RELATING TO IN-**
6 **DIRECT COSTS.**

7 “(a) IN GENERAL.—For purposes of section
8 2211(a)(1), the amount determined under this section for
9 a teaching hospital for a fiscal year is the product of—

10 “(1) the amount in the Indirect-Costs Medical
11 Education Account on the applicable date under sec-
12 tion 2201(d) (once the appropriation under such sec-
13 tion is made); and

14 “(2) the percentage determined for the hospital
15 under subsection (b).

16 “(b) HOSPITAL-SPECIFIC PERCENTAGE.—

17 “(1) IN GENERAL.—For purposes of subsection
18 (a)(2), the percentage determined under this sub-
19 section for a teaching hospital is the mean average
20 of the respective percentages determined under para-
21 graph (3) for each fiscal year of the applicable pe-
22 riod (as defined in paragraph (2)), adjusted by the
23 Secretary (upward or downward, as the case may
24 be) on a pro rata basis to the extent necessary to
25 ensure that the sum of the percentages determined

1 under this paragraph for all teaching hospitals is
2 equal to 100 percent. The preceding sentence is sub-
3 ject to sections 2222 and 2223.

4 “(2) APPLICABLE PERIOD REGARDING REL-
5 EVANT DATA; FISCAL YEARS 1992 THROUGH 1994.—
6 For purposes of this part, the term ‘applicable pe-
7 riod’ means the period beginning on the first day of
8 fiscal year 1992 and continuing through the end of
9 fiscal year 1994.

10 “(3) RESPECTIVE DETERMINATIONS FOR FIS-
11 CAL YEARS OF APPLICABLE PERIOD.—For purposes
12 of paragraph (1), the percentage determined under
13 this paragraph for a teaching hospital for a fiscal
14 year of the applicable period is the percentage con-
15 stituted by the ratio of—

16 “(A) the total amount of payments re-
17 ceived by the hospital under section
18 1886(d)(5)(B) for discharges occurring during
19 the fiscal year involved; to

20 “(B) the sum of the respective amounts
21 determined under subparagraph (A) for the fis-
22 cal year for all teaching hospitals.

23 “(c) AVAILABILITY OF DATA.—If a teaching hospital
24 received the payments specified in subsection (b)(3)(A)
25 during the applicable period but a complete set of the rel-

1 evant data is not available to the Secretary for purposes
 2 of determining an amount under such subsection for the
 3 fiscal year involved, the Secretary shall for purposes of
 4 such subsection make an estimate on the basis of such
 5 data as are available to the Secretary for the applicable
 6 period.

7 **“SEC. 2222. INDIRECT COSTS; SPECIAL RULES REGARDING**
 8 **DETERMINATION OF HOSPITAL-SPECIFIC**
 9 **PERCENTAGE.**

10 “(a) SPECIAL RULE REGARDING FISCAL YEARS
 11 1995 AND 1996.—

12 “(1) IN GENERAL.—In the case of a teaching
 13 hospital whose first payments under section
 14 1886(d)(5)(B) were for discharges occurring in fis-
 15 cal year 1995 or in fiscal year 1996 (referred to in
 16 this subsection individually as a ‘first payment
 17 year’), the percentage determined under paragraph
 18 (2) for the hospital is deemed to be the percentage
 19 applicable under section 2221(b) to the hospital, ex-
 20 cept that the percentage under paragraph (2) shall
 21 be adjusted in accordance with section 2221(b)(1) to
 22 the extent determined by the Secretary to be nec-
 23 essary with respect to a sum that equals 100 per-
 24 cent.

1 “(2) DETERMINATION OF PERCENTAGE.—For
2 purposes of paragraph (1), the percentage deter-
3 mined under this paragraph for a teaching hospital
4 is the percentage constituted by the ratio of the
5 amount determined under subparagraph (A) to the
6 amount determined under subparagraph (B), as fol-
7 lows:

8 “(A)(i) If the first payment year for the
9 hospital is fiscal year 1995, the amount deter-
10 mined under this subparagraph is the total
11 amount of payments received by the hospital
12 under section 1886(d)(5)(B) for discharges oc-
13 curring during fiscal year 1995.

14 “(ii) If the first payment year for the hos-
15 pital is fiscal year 1996, the amount determined
16 under this subparagraph is an amount equal to
17 an estimate by the Secretary of the total
18 amount of payments that would have been paid
19 to the hospital under section 1886(d)(5)(B) for
20 discharges occurring during fiscal year 1995 if
21 such section, as in effect for fiscal year 1996,
22 had applied to the hospital for discharges occur-
23 ring during fiscal year 1995.

24 “(B)(i) If the first payment year for the
25 hospital is fiscal year 1995, the amount deter-

1 mined under this subparagraph is the aggregate
2 total of the payments received by teaching hos-
3 pitals under section 1886(d)(5)(B) for dis-
4 charges occurring during fiscal year 1995.

5 “(ii) If the first payment year for the hos-
6 pital is fiscal year 1996—

7 “(I) the Secretary shall make an esti-
8 mate in accordance with subparagraph
9 (A)(ii) for all teaching hospitals; and

10 “(II) the amount determined under
11 this subparagraph is the sum of the esti-
12 mates made by the Secretary under
13 subclause (I).

14 “(b) NEW TEACHING HOSPITALS.—

15 “(1) IN GENERAL.—Subject to paragraph (4),
16 in the case of a teaching hospital that did not re-
17 ceive payments under section 1886(d)(5)(B) for any
18 of the fiscal years 1992 through 1996, the percent-
19 age determined under paragraph (3) for the hospital
20 is deemed to be the percentage applicable under sec-
21 tion 2221(b) to the hospital, except that the percent-
22 age under paragraph (3) shall be adjusted in accord-
23 ance with section 2221(b)(1) to the extent deter-
24 mined by the Secretary to be necessary with respect
25 to a sum that equals 100 percent.

1 “(2) DESIGNATED FISCAL YEAR REGARDING
2 DATA.—The determination under paragraph (3) of a
3 percentage for a teaching hospital described in para-
4 graph (1) shall be made for the most recent fiscal
5 year for which the Secretary has sufficient data to
6 make the determination (referred to in this sub-
7 section as the ‘designated fiscal year’).

8 “(3) DETERMINATION OF PERCENTAGE.—For
9 purposes of paragraph (1), the percentage deter-
10 mined under this paragraph for the teaching hos-
11 pital involved is the percentage constituted by the
12 ratio of the amount determined under subparagraph
13 (A) to the amount determined under subparagraph
14 (B), as follows:

15 “(A) The amount determined under this
16 subparagraph is an amount equal to an esti-
17 mate by the Secretary of the total amount of
18 payments that would have been paid to the hos-
19 pital under section 1886(d)(5)(B) for the des-
20 ignated fiscal year if such section, as in effect
21 for the first fiscal year for which payments pur-
22 suant to this subsection are to be made to the
23 hospital, had applied to the hospital for the des-
24 ignated fiscal year.

“(B) The Secretary shall make an estimate in accordance with subparagraph (A) for all teaching hospitals. The amount determined under this subparagraph is the sum of the estimates made by the Secretary under the preceding sentence.

“(4) LIMITATION.—This subsection does not apply to a teaching hospital described in paragraph (1) if the hospital is in a State for which a demonstration project under section 1814(b)(3) is in effect.

“(c) CONSOLIDATIONS AND MERGERS.—In the case of two or more teaching hospitals that have each received payments pursuant to section 2221 for one or more fiscal years and that undergo a consolidation or merger, the percentage applicable to the resulting teaching hospital for purposes of section 2221(b) is the sum of the respective percentages that would have applied pursuant to such section if the hospitals had not undergone the consolidation or merger.

21 **“SEC. 2223. INDIRECT COSTS; ALTERNATIVE PAYMENTS RE-**
22 **GARDING TEACHING HOSPITALS IN CERTAIN**
23 **STATES.**

24 “(a) IN GENERAL.—In the case of a teaching hospital
25 in a State for which a demonstration project under section

1 1814(b)(3) is in effect, this section applies in lieu of sec-
 2 tion 2221. For purposes of section 2211(a)(1), the amount
 3 determined for such a teaching hospital for a fiscal year
 4 is the product of—

5 “(1) the amount in the Indirect-Costs Medical
 6 Education Account for the fiscal year pursuant to
 7 the allocation under section 2201(d)(3)(A) for the
 8 year; and

9 “(2) the percentage determined under sub-
 10 section (b) for the hospital.

11 “(b) DETERMINATION OF PERCENTAGE.—For pur-
 12 poses of subsection (a)(2):

13 “(1) The Secretary shall make an estimate of
 14 the total amount of payments that would have been
 15 received under section 1886(d)(5)(B) by the hospital
 16 involved with respect to each of the fiscal years of
 17 the applicable period if such section (as in effect for
 18 such fiscal years) had applied to the hospital for
 19 such years.

20 “(2) The percentage determined under this sub-
 21 section for the hospital for a fiscal year is a mean
 22 average percentage determined for the hospital in
 23 accordance with the methodology of section
 24 2221(b)(1), except that the estimate made by the
 25 Secretary under paragraph (1) of this subsection for

1 a fiscal year of the applicable period is deemed to be
2 the amount that applies for purposes of section
3 2221(b)(3)(A) for such year.

4 “(c) RULE REGARDING PAYMENTS FROM CERTAIN
5 AMOUNTS.—In the case of a teaching hospital described
6 in subsection (a), this section does not authorize any pay-
7 ment to the hospital from amounts transferred to the
8 Fund under section 1886(j).

9 “(d) ADJUSTMENT REGARDING PAYMENTS TO
10 OTHER HOSPITALS.—In the case of a fiscal year for which
11 payments pursuant to subsection (a) are made to one or
12 more teaching hospitals, the following applies:

13 “(1) The Secretary shall determine a percent-
14 age equal to the sum of the respective percentages
15 determined for the hospitals under subsection (b).

16 “(2) The Secretary shall determine an amount
17 equal to the product of—

18 “(A) the percentage determined under
19 paragraph (1); and

20 “(B) the amount in the Indirect-Costs
21 Medical Education Account for the fiscal year
22 pursuant to the transfer under section
23 1886(j)(1).

24 “(3) The Secretary shall, for each hospital
25 (other than hospitals described in subsection (a)),

1 make payments to the hospital in amounts whose
2 sum for the fiscal year is equal to the product of—

3 “(A) the amount determined under para-
4 graph (2); and

5 “(B) the percentage that applies to the
6 hospital for purposes of section 2221(b), except
7 that such percentage shall be adjusted in ac-
8 cordance with the methodology of section
9 2221(b)(1) to the extent determined by the Sec-
10 retary to be necessary with respect to a sum
11 that equals 100 percent.

12 “Subpart 3—Amount Relating to Direct Costs of
13 Graduate Medical Education

14 **“SEC. 2231. DETERMINATION OF AMOUNT RELATING TO DI-**
15 **RECT COSTS.**

16 “(a) IN GENERAL.—For purposes of section
17 2211(a)(2), the amount determined under this section for
18 a teaching hospital for a fiscal year is the sum of—

19 “(1) the amount determined under subsection
20 (b) (relating to the General Direct-Costs Medical
21 Education Account); and

22 “(2) the amount determined under subsection
23 (c) (relating to the Medicare Direct-Costs Medical
24 Education Account).

25 “(b) PAYMENT FROM GENERAL ACCOUNT.—

1 “(1) IN GENERAL.—For purposes of subsection
2 (a)(1), the amount determined under this subsection
3 for a teaching hospital for a fiscal year is the prod-
4 uct of—

5 “(A) the amount in the General Direct-
6 Costs Medical Education Account on the appli-
7 cable date under section 2201(d) (once the ap-
8 propriation under such section is made); and

9 “(B) the percentage determined for the
10 hospital under paragraph (2).

11 “(2) HOSPITAL-SPECIFIC PERCENTAGE.—

12 “(A) IN GENERAL.—For purposes of para-
13 graph (1)(B), the percentage determined under
14 this paragraph for a teaching hospital is the
15 mean average of the respective percentages de-
16 termined under subparagraph (B) for each fis-
17 cal year of the applicable period (as defined in
18 section 2221(b)(2)), adjusted by the Secretary
19 (upward or downward, as the case may be) on
20 a pro rata basis to the extent necessary to en-
21 sure that the sum of the percentages deter-
22 mined under this subparagraph for all teaching
23 hospitals is equal to 100 percent. The preceding
24 sentence is subject to sections 2232 through
25 2234.

1 “(B) RESPECTIVE DETERMINATIONS FOR
2 FISCAL YEARS OF APPLICABLE PERIOD.—For
3 purposes of subparagraph (A), the percentage
4 determined under this subparagraph for a
5 teaching hospital for a fiscal year of the appli-
6 cable period is the percentage constituted by
7 the ratio of—

8 “(i) the total amount of payments re-
9 ceived by the hospital under section
10 1886(h) for cost reporting periods begin-
11 ning during the fiscal year involved; to

12 “(ii) the sum of the respective
13 amounts determined under clause (i) for
14 the fiscal year for all teaching hospitals.

15 “(3) AVAILABILITY OF DATA.—If a teaching
16 hospital received the payments specified in para-
17 graph (2)(B)(i) during the applicable period but a
18 complete set of the relevant data is not available to
19 the Secretary for purposes of determining an
20 amount under such paragraph for the fiscal year in-
21 volved, the Secretary shall for purposes of such
22 paragraph make an estimate on the basis of such
23 data as are available to the Secretary for the appli-
24 cable period.

25 “(c) PAYMENT FROM MEDICARE ACCOUNT.—

1 “(1) IN GENERAL.—For purposes of subsection
2 (a)(2), the amount determined under this subsection
3 for a teaching hospital for a fiscal year is the prod-
4 uct of—

5 “(A) the amount in the Medicare Direct-
6 Costs Medical Education Account on the appli-
7 cable date under section 2201(d) (once the ap-
8 propriation under such section is made); and

9 “(B) the percentage determined for the
10 hospital under paragraph (2) for the fiscal year.

11 “(2) HOSPITAL-SPECIFIC PERCENTAGE.—For
12 purposes of paragraph (1)(B), the percentage deter-
13 mined under this subsection for a teaching hospital
14 for a fiscal year is the percentage constituted by the
15 ratio of—

16 “(A) the estimate made by the Secretary
17 for the hospital for the fiscal year under section
18 1886(j)(2)(B); to

19 “(B) the sum of the respective estimates
20 referred to in subparagraph (A) for all teaching
21 hospitals.

1 **“SEC. 2232. DIRECT COSTS; SPECIAL RULES REGARDING**
 2 **DETERMINATION OF HOSPITAL-SPECIFIC**
 3 **PERCENTAGE.**

4 “(a) SPECIAL RULE REGARDING FISCAL YEARS
 5 1995 AND 1996.—

6 “(1) IN GENERAL.—In the case of a teaching
 7 hospital whose first payments under section 1886(h)
 8 were for the cost reporting period beginning in fiscal
 9 year 1995 or in fiscal year 1996 (referred to in this
 10 subsection individually as a ‘first payment year’),
 11 the percentage determined under paragraph (2) for
 12 the hospital is deemed to be the percentage applica-
 13 ble under section 2231(b)(2) to the hospital, except
 14 that the percentage under paragraph (2) shall be ad-
 15 justed in accordance with section 2231(b)(2)(A) to
 16 the extent determined by the Secretary to be nec-
 17 essary with respect to a sum that equals 100 per-
 18 cent.

19 “(2) DETERMINATION OF PERCENTAGE.—For
 20 purposes of paragraph (1), the percentage deter-
 21 mined under this paragraph for a teaching hospital
 22 is the percentage constituted by the ratio of the
 23 amount determined under subparagraph (A) to the
 24 amount determined under subparagraph (B), as fol-
 25 lows:

1 “(A)(i) If the first payment year for the
2 hospital is fiscal year 1995, the amount deter-
3 mined under this subparagraph is the total
4 amount of payments received by the hospital
5 under section 1886(h) for cost reporting periods
6 beginning in fiscal year 1995.

7 “(ii) If the first payment year for the hos-
8 pital is fiscal year 1996, the amount determined
9 under this subparagraph is an amount equal to
10 an estimate by the Secretary of the total
11 amount of payments that would have been paid
12 to the hospital under section 1886(h) for cost
13 reporting periods beginning in fiscal year 1995
14 if such section, as in effect for fiscal year 1996,
15 had applied to the hospital for fiscal year 1995.

16 “(B)(i) If the first payment year for the
17 hospital is fiscal year 1995, the amount deter-
18 mined under this subparagraph is the aggregate
19 total of the payments received by teaching hos-
20 pitals under section 1886(h) for cost reporting
21 periods beginning in fiscal year 1995.

22 “(ii) If the first payment year for the hos-
23 pital is fiscal year 1996—

1 “(I) the Secretary shall make an esti-
 2 mate in accordance with subparagraph
 3 (A)(ii) for all teaching hospitals; and

4 “(II) the amount determined under
 5 this subparagraph is the sum of the esti-
 6 mates made by the Secretary under
 7 subclause (I).

8 “(b) NEW TEACHING HOSPITALS.—

9 “(1) IN GENERAL.—Subject to paragraph (4),
 10 in the case of a teaching hospital that did not re-
 11 ceive payments under section 1886(h) for any of the
 12 fiscal years 1992 through 1996, the percentage de-
 13 termined under paragraph (3) for the hospital is
 14 deemed to be the percentage applicable under section
 15 2231(b)(2) to the hospital, except that the percent-
 16 age under paragraph (3) shall be adjusted in accord-
 17 ance with section 2231(b)(2)(A) to the extent deter-
 18 mined by the Secretary to be necessary with respect
 19 to a sum that equals 100 percent.

20 “(2) DESIGNATED FISCAL YEAR REGARDING
 21 DATA.—The determination under paragraph (3) of a
 22 percentage for a teaching hospital described in para-
 23 graph (1) shall be made for the most recent fiscal
 24 year for which the Secretary has sufficient data to

1 make the determination (referred to in this sub-
2 section as the ‘designated fiscal year’).

3 “(3) DETERMINATION OF PERCENTAGE.—For
4 purposes of paragraph (1), the percentage deter-
5 mined under this paragraph for the teaching hos-
6 pital involved is the percentage constituted by the
7 ratio of the amount determined under subparagraph
8 (A) to the amount determined under subparagraph
9 (B), as follows:

10 “(A) The amount determined under this
11 subparagraph is an amount equal to an esti-
12 mate by the Secretary of the total amount of
13 payments that would have been paid to the hos-
14 pital under section 1886(h) for the designated
15 fiscal year if such section, as in effect for the
16 first fiscal year for which payments pursuant to
17 this subsection are to be made to the hospital,
18 had applied to the hospital for cost reporting
19 periods beginning in the designated fiscal year.

20 “(B) The Secretary shall make an estimate
21 in accordance with subparagraph (A) for all
22 teaching hospitals. The amount determined
23 under this subparagraph is the sum of the esti-
24 mates made by the Secretary under the preced-
25 ing sentence.

1 “(4) LIMITATION.—This subsection does not
2 apply to a teaching hospital described in paragraph
3 (1) if the hospital is in a State for which a dem-
4 onstration project under section 1814(b)(3) is in ef-
5 fect.

6 “(c) CONSOLIDATIONS AND MERGERS.—In the case
7 of two or more teaching hospitals that have each received
8 payments pursuant to section 2231 for one or more fiscal
9 years and that undergo a consolidation or merger, the per-
10 centage applicable to the resulting teaching hospital for
11 purposes of section 2231(b) is the sum of the respective
12 percentages that would have applied pursuant to such sec-
13 tion if the hospitals had not undergone the consolidation
14 or merger.

15 **“SEC. 2233. DIRECT COSTS; AUTHORITY FOR PAYMENTS TO**
16 **CONSORTIA OF PROVIDERS.**

17 “(a) IN GENERAL.—In lieu of making payments to
18 teaching hospitals pursuant to section 2231, the Secretary
19 may make payments under this section to consortia that
20 meet the requirements of subsection (b).

21 “(b) QUALIFYING CONSORTIUM.—For purposes of
22 subsection (a), a consortium meets the requirements of
23 this subsection if the consortium is in compliance with the
24 following:

1 “(1) The consortium consists of an approved
2 medical residency training program and one or more
3 of the following entities:

4 “(A) Schools of allopathic medicine or os-
5 teopathic medicine.

6 “(B) Teaching hospitals.

7 “(C) Other approved medical residency
8 training programs.

9 “(D) Federally qualified health centers.

10 “(E) Medical group practices.

11 “(F) Managed care entities.

12 “(G) Entities furnishing outpatient serv-
13 ices.

14 “(H) Such other entities as the Secretary
15 determines to be appropriate.

16 “(2) The members of the consortium have
17 agreed to participate in the programs of graduate
18 medical education that are operated by the entities
19 in the consortium.

20 “(3) With respect to the receipt by the consor-
21 tium of payments made pursuant to this section, the
22 members of the consortium have agreed on a method
23 for allocating the payments among the members.

24 “(4) The consortium meets such additional re-
25 quirements as the Secretary may establish.

1 “(c) PAYMENTS FROM ACCOUNTS.—

2 “(1) IN GENERAL.—Subject to subsection (d),
3 the total of payments to a qualifying consortium for
4 a fiscal year pursuant to subsection (a) shall be the
5 sum of—

6 “(1) the aggregate amount determined for the
7 teaching hospitals of the consortium pursuant to
8 paragraph (1) of section 2231(a); and

9 “(2) an amount determined in accordance with
10 the methodology that applies pursuant to paragraph
11 (2) of such section, except that the estimate used for
12 purposes of subsection (c)(2)(A) of such section shall
13 be the estimate made for the consortium under sec-
14 tion 1886(j)(2)(C)(ii).

15 “(d) LIMITATION ON AGGREGATE TOTAL OF PAY-
16 MENTS TO CONSORTIA.—The aggregate total of the
17 amounts paid under subsection (c)(2) to qualifying consor-
18 tia for a fiscal year may not exceed the sum of—

19 “(1) the aggregate total of the amounts that
20 would have been paid under section 2231(c) for the
21 fiscal year to the teaching hospitals of the consortia
22 if the hospitals had not been participants in the con-
23 sortia; and

24 “(2) an amount equal to 1 percent of the
25 amount that applies under section 2231(c)(1)(A) for

1 the fiscal year (relating to the Medicare Direct-Costs
2 Medical Education Account).

3 “(e) DEFINITION.—For purposes of this title, the
4 term ‘qualifying consortium’ means a consortium that
5 meets the requirements of subsection (b).

6 **“SEC. 2234. DIRECT COSTS; ALTERNATIVE PAYMENTS RE-**
7 **GARDING TEACHING HOSPITALS IN CERTAIN**
8 **STATES.**

9 “(a) IN GENERAL.—In the case of a teaching hospital
10 in a State for which a demonstration project under section
11 1814(b)(3) is in effect, this section applies in lieu of sec-
12 tion 2231. For purposes of section 2211(a)(2), the amount
13 determined for a teaching hospital for a fiscal year is the
14 product of—

15 “(1) the amount in the General Direct-Costs
16 Medical Education Account on the applicable date
17 under section 2201(d) (once the appropriation under
18 such section is made); and

19 “(2) the percentage determined under sub-
20 section (b) for the hospital.

21 “(b) DETERMINATION OF PERCENTAGE.—For pur-
22 poses of subsection (a)(2):

23 “(1) The Secretary shall make an estimate of
24 the total amount of payments that would have been
25 received under section 1886(h) by the hospital in-

1 volved with respect to each of the fiscal years of the
2 applicable period if such section (as in effect for
3 such fiscal years) had applied to the hospital for
4 such years.

5 “(2) The percentage determined under this sub-
6 section for the hospital for a fiscal year is a mean
7 average percentage determined for the hospital in
8 accordance with the methodology of section
9 2231(b)(2)(A), except that the estimate made by the
10 Secretary under paragraph (1) of this subsection for
11 a fiscal year of the applicable period is deemed to be
12 the amount that applies for purposes of section
13 2231(b)(2)(B)(i) for such year.

14 “(c) RULE REGARDING PAYMENTS FROM CERTAIN
15 AMOUNTS.—In the case of a teaching hospital described
16 in subsection (a), this section does not authorize any pay-
17 ment to the hospital from amounts transferred to the
18 Fund under section 1886(j).

19 “Subpart 4—General Provisions

20 **“SEC. 2241. ADJUSTMENTS IN PAYMENT AMOUNTS.**

21 “(a) COLLECTION OF DATA ON ACCURACY OF ESTI-
22 MATES.—The Secretary shall collect data on whether the
23 estimates made by the Secretary under section 1886(j) for
24 a fiscal year were substantially accurate.

1 “(b) ADJUSTMENTS.—If the Secretary determines
2 under subsection (a) that an estimate for a fiscal year was
3 not substantially accurate, the Secretary shall, for the first
4 fiscal year beginning after the Secretary makes the deter-
5 mination—

6 “(1) make adjustments accordingly in transfers
7 to the Fund under section 1886(j); and

8 “(2) make adjustments accordingly in the
9 amount of payments to teaching hospitals pursuant
10 to 2231(c) (or, as applicable, to qualifying consortia
11 pursuant to section 2233(c)(2)).”.

12 **PART 2—AMENDMENTS TO MEDICARE PROGRAM**

13 **SEC. 15411. TRANSFERS TO TEACHING HOSPITAL AND**

14 **GRADUATE MEDICAL EDUCATION TRUST**

15 **FUND.**

16 Section 1886 (42 U.S.C. 1395ww) is amended—

17 (1) in subsection (d)(5)(B), in the matter pre-
18 ceding clause (i), by striking “The Secretary shall
19 provide” and inserting the following: “For dis-
20 charges occurring on or before September 30, 1996,
21 the Secretary shall provide”;

22 (2) in subsection (h)—

23 (A) in paragraph (1), in the first sentence,
24 by striking “the Secretary shall provide” and

1 inserting “the Secretary shall, subject to para-
2 graph (6), provide”; and

3 (B) by adding at the end the following
4 paragraph:

5 “(6) LIMITATION.—

6 “(A) IN GENERAL.—The authority to
7 make payments under this subsection applies
8 only with respect to cost reporting periods end-
9 ing on or before September 30, 1996, except as
10 provided in subparagraph (B).

11 “(B) RULE REGARDING PORTION OF LAST
12 COST REPORTING PERIOD.—In the case of a
13 cost reporting period that extends beyond Sep-
14 tember 30, 1996, payments under this sub-
15 section shall be made with respect to such por-
16 tion of the period as has lapsed as of such date.

17 “(C) RULE OF CONSTRUCTION.—This
18 paragraph may not be construed as authorizing
19 any payment under section 1861(v) with re-
20 spect to graduate medical education.”; and

21 (3) by adding at the end the following sub-
22 section:

23 “(j) TRANSFERS TO TEACHING HOSPITAL AND
24 GRADUATE MEDICAL EDUCATION TRUST FUND.—

1 “(1) INDIRECT COSTS OF MEDICAL EDU-
2 CATION.—

3 “(A) IN GENERAL.—From the Federal
4 Hospital Insurance Trust Fund, the Secretary
5 shall, for fiscal year 1997 and each subsequent
6 fiscal year, transfer to the Indirect-Costs Medi-
7 cal Education Account (under section 2201) an
8 amount determined by the Secretary in accord-
9 ance with subparagraph (B).

10 “(B) DETERMINATION OF AMOUNTS.—The
11 Secretary shall make an estimate for the fiscal
12 year involved of the nationwide total of the
13 amounts that would have been paid under sub-
14 section (d)(5)(B) to hospitals during the fiscal
15 year if such payments had not been terminated
16 for discharges occurring after September 30,
17 1996. For purposes of subparagraph (A), the
18 amount determined under this subparagraph
19 for the fiscal year is the estimate made by the
20 Secretary under the preceding sentence.

21 “(2) DIRECT COSTS OF MEDICAL EDUCATION.—

22 “(A) IN GENERAL.—From the Federal
23 Hospital Insurance Trust Fund and the Fed-
24 eral Supplementary Medical Insurance Trust
25 Fund, the Secretary shall, for fiscal year 1997

1 and each subsequent fiscal year, transfer to the
 2 Medicare Direct-Costs Medical Education Ac-
 3 count (under section 2201) the sum of—

4 “(i) an amount determined by the
 5 Secretary in accordance with subparagraph
 6 (B); and

7 “(ii) as applicable, an amount deter-
 8 mined by the Secretary in accordance with
 9 subparagraph (C)(ii).

10 “(B) DETERMINATION OF AMOUNTS.—For
 11 each hospital (other than a hospital that is a
 12 member of a qualifying consortium referred to
 13 in subparagraph (C)), the Secretary shall make
 14 an estimate for the fiscal year involved of the
 15 amount that would have been paid under sub-
 16 section (h) to the hospital during the fiscal year
 17 if such payments had not been terminated for
 18 cost reporting periods ending on or before Sep-
 19 tember 30, 1996. For purposes of subparagraph
 20 (A)(i), the amount determined under this sub-
 21 paragraph for the fiscal year is the sum of all
 22 estimates made by the Secretary under the pre-
 23 ceding sentence.

24 “(C) ESTIMATES REGARDING QUALIFYING
 25 CONSORTIA.—If the Secretary elects to author-

1 ize one or more qualifying consortia for pur-
2 poses of section 2233(a), the Secretary shall
3 carry out the following:

4 “(i) The Secretary shall establish a
5 methodology for making payments to quali-
6 fying consortia with respect to the reason-
7 able direct costs of such consortia in carry-
8 ing out programs of graduate medical edu-
9 cation. The methodology shall be the meth-
10 odology established in subsection (h),
11 modified to the extent necessary to take
12 into account the participation in such pro-
13 grams of entities other than hospitals.

14 “(ii) For each qualifying consortium,
15 the Secretary shall make an estimate for
16 the fiscal year involved of the amount that
17 would have been paid to the consortium
18 during the fiscal year if, using the meth-
19 odology under clause (i), payments had
20 been made to the consortium for the fiscal
21 year as reimbursements with respect to
22 cost reporting periods. For purposes of
23 subparagraph (A)(ii), the amount deter-
24 mined under this clause for the fiscal year

1 is the sum of all estimates made by the
2 Secretary under the preceding sentence.

3 “(D) ALLOCATION BETWEEN FUNDS.—In
4 providing for a transfer under subparagraph
5 (A) for a fiscal year, the Secretary shall provide
6 for an allocation of the amounts involved be-
7 tween part A and part B (and the trust funds
8 established under the respective parts) as rea-
9 sonably reflects the proportion of direct grad-
10 uate medical education costs of hospitals associ-
11 ated with the provision of services under each
12 respective part.

13 “(3) APPLICABILITY OF CERTAIN AMEND-
14 MENTS.—Amendments made to subsection (d)(5)(B)
15 and subsection (h) that are effective on or after Oc-
16 tober 1, 1996, apply only for purposes of estimates
17 under paragraphs (1) and (2) and for purposes of
18 determining the amount of payments under 2211.
19 Such amendments do not require any adjustment to
20 amounts paid under subsection (d)(5)(B) or (h) with
21 respect to fiscal year 1996 or any prior fiscal year.

22 “(4) RELATIONSHIP TO CERTAIN DEMONSTRA-
23 TION PROJECTS.—In the case of a State for which
24 a demonstration project under section 1814(b)(3) is
25 in effect, the Secretary, in making determinations of

1 the rates of increase under such section, shall in-
 2 clude all amounts transferred under this subsection.
 3 Such amounts shall be so included to the same ex-
 4 tent and in the same manner as amounts determined
 5 under subsections (d)(5)(B) and (h) were included in
 6 such determination under the provisions of this title
 7 in effect on September 30, 1996.”.

8 **SEC. 15412. MODIFICATION IN PAYMENT POLICIES REGARD-**
 9 **ING GRADUATE MEDICAL EDUCATION.**

10 (a) INDIRECT COSTS OF MEDICAL EDUCATION; AP-
 11 PLICABLE PERCENTAGE.—

12 (1) MODIFICATION REGARDING 5.6 PERCENT.—

13 Section 1886(d)(5)(B)(ii) (42 U.S.C.
 14 1395ww(d)(5)(B)(ii)) is amended—

15 (A) by striking “on or after October 1,
 16 1988,” and inserting “on or after October 1,
 17 1999,”; and

18 (B) by striking “1.89” and inserting
 19 “1.38”.

20 (2) SPECIAL RULE REGARDING FISCAL YEARS

21 1996 THROUGH 1998; MODIFICATION REGARDING 6

22 PERCENT.—Section 1886(d)(5)(B)(ii), as amended

23 by paragraph (1), is amended by adding at the end

24 the following: “In the case of discharges occurring

25 on or after October 1, 1995, and before October 1,

1 1999, the preceding sentence applies to the same ex-
 2 tent and in the same manner as the sentence applies
 3 to discharges occurring on or after October 1, 1999,
 4 except that the term ‘1.38’ is deemed to be ‘1.48’.”.

5 (3) CONFORMING AMENDMENT RELATING TO
 6 DETERMINATION OF STANDARDIZED AMOUNTS.—

7 Section 1886(d)(2)(C)(i) (42 U.S.C.
 8 1395ww(d)(2)(C)(i)) is amended by striking “1985”
 9 and inserting the following: “1985, but (for dis-
 10 charges occurring after September 30, 1995) not
 11 taking into account any reductions in such costs re-
 12 sulting from the amendments made by section
 13 15412(a) of the Medicare Preservation Act of
 14 1995”.

15 (b) DIRECT COSTS OF MEDICAL EDUCATION.—

16 (1) LIMITATION ON NUMBER OF FULL-TIME-
 17 EQUIVALENT RESIDENTS.—Section 1886(h)(4) (42
 18 U.S.C. 1395ww(h)(4)) is amended by adding at the
 19 end the following new subparagraph:

20 “(F) LIMITATION ON NUMBER OF RESI-
 21 DENTS FOR CERTAIN FISCAL YEARS.—

22 “(i) IN GENERAL.—Such rules shall
 23 provide that for purposes of a cost report-
 24 ing period beginning on or after October 1,
 25 1995, and on or before September 30,

1 2002, the number of full-time-equivalent
 2 residents determined under this paragraph
 3 with respect to an approved medical resi-
 4 dency training program may not exceed
 5 the number of full-time-equivalent resi-
 6 dents with respect to the program as of
 7 August 1, 1995 (except that this subpara-
 8 graph applies only to approved medical
 9 residency training programs in the fields of
 10 allopathic medicine and osteopathic medi-
 11 cine).

12 “(ii) DISPOSITION OF UNUSED RESI-
 13 DENCY POSITIONS.—In the case of a cost
 14 reporting period to which the limitation
 15 under clause (i) applies, if for such a pe-
 16 riod the number of full-time-equivalent
 17 residents determined under this paragraph
 18 with respect to an approved medical resi-
 19 dency training program is less than the
 20 maximum number applicable to the pro-
 21 gram under such clause, the Secretary may
 22 authorize for one or more other approved
 23 medical residency training programs offset-
 24 ting increases in the respective maximum
 25 numbers that otherwise would be applica-

1 ble under such clause to the programs. In
2 authorizing such increases with respect to
3 a cost reporting period, the Secretary shall
4 ensure that the national total of the re-
5 spective maximum numbers determined
6 under such clause with respect to approved
7 medical residency training programs is not
8 exceeded.”.

9 (2) EXCLUSION OF RESIDENTS AFTER INITIAL
10 RESIDENCY PERIOD.—Section 1886(h)(4)(C) (42
11 U.S.C. 1395ww(h)(4)(C)) is amended to read as fol-
12 lows:

13 “(C) WEIGHTING FACTORS FOR RESI-
14 DENTS.—Effective for cost reporting periods
15 beginning on or after October 1, 1997, such
16 rules shall provide that, in the calculation of the
17 number of full-time-equivalent residents in an
18 approved residency program, the weighting fac-
19 tor for a resident who is in the initial residency
20 period (as defined in paragraph (5)(F)) is 1.0
21 and the weighting factor for a resident who has
22 completed such period is 0.0. (In the case of
23 cost reporting periods beginning before October
24 1, 1997, the weighting factors that apply in
25 such calculation are the weighting factors that

1 were applicable under this subparagraph on the
2 day before the date of the enactment of the
3 Medicare Preservation Act of 1995.)”.

4 (3) REDUCTIONS IN PAYMENTS FOR ALIEN
5 RESIDENTS.—Section 1886(h)(4) (42 U.S.C.
6 1395ww(h)(4)), as amended by paragraph (1), is
7 amended by adding at the end the following new
8 subparagraph:

9 “(G) SPECIAL RULES FOR ALIEN RESI-
10 DENTS.—In the case of individuals who are not
11 citizens or nationals of the United States, aliens
12 lawfully admitted to the United States for per-
13 manent residence, aliens admitted to the United
14 States as refugees, or citizens of Canada, in the
15 calculation of the number of full-time-equivalent
16 residents in an approved medical residency pro-
17 gram, the following rules shall apply with re-
18 spect to such individuals who are residents in
19 the program:

20 “(i) For a cost reporting period begin-
21 ning during fiscal year 1996, for each such
22 individual the Secretary shall apply a
23 weighting factor of .75.

24 “(ii) For a cost reporting period be-
25 ginning during fiscal year 1997, for each

1 such individual the Secretary shall apply a
2 weighting factor of .50.

3 “(iii) For a cost reporting period be-
4 ginning during fiscal year 1998 or any
5 subsequent fiscal year, for each such indi-
6 vidual the Secretary shall apply a
7 weighting factor of .25.”.

8 (4) EFFECTIVE DATE.—Except as provided oth-
9 erwise in this subsection (or in the amendments
10 made by this subsection), the amendments made by
11 this subsection apply to hospital cost reporting peri-
12 ods beginning on or after October 1, 1995.

13 **PART 3—REFORM OF FEDERAL POLICIES RE-**
14 **GARDING TEACHING HOSPITALS AND GRAD-**
15 **UATE MEDICAL EDUCATION**

16 **SEC. 15421. ESTABLISHMENT OF ADVISORY PANEL FOR**
17 **RECOMMENDING POLICIES.**

18 Title XXII of the Social Security Act, as added by
19 section 15401, is amended by adding at the end the follow-
20 ing part:

1 “PART C—OTHER MATTERS
2 **“SEC. 2251. ADVISORY PANEL ON REFORM IN FINANCING**
3 **OF TEACHING HOSPITALS AND GRADUATE**
4 **MEDICAL EDUCATION.**

5 “(a) ESTABLISHMENT.—The Chair of the Medicare
6 Payment Review Commission under section 1806 shall es-
7 tablish a temporary advisory panel to be known as the Ad-
8 visory Panel on Financing for Teaching Hospitals and
9 Graduate Medical Education (in this section referred to
10 as the ‘Panel’).

11 “(b) DUTIES.—The Panel shall develop recommenda-
12 tions on whether and to what extent Federal policies re-
13 garding teaching hospitals and graduate medical edu-
14 cation should be reformed, including recommendations re-
15 garding the following:

16 “(1) The financing of graduate medical edu-
17 cation, including consideration of alternative broad-
18 based sources of funding for such education.

19 “(2) The financing of teaching hospitals, in-
20 cluding consideration of the difficulties encountered
21 by such hospitals as competition among health care
22 entities increases. Matters considered under this
23 paragraph shall include consideration of the effects
24 on teaching hospitals of the method of financing

1 used for the MedicarePlus program under part C of
2 title XVIII.

3 “(3) The methodology for making payments for
4 graduate medical education, and the selection of en-
5 tities to receive the payments. Matters considered
6 under this paragraph shall include the following:

7 “(A) The methodology under part B for
8 making payments from the Fund, including the
9 use of data from the fiscal years 1992 through
10 1994, and including the methodology that ap-
11 plies with respect to consolidations and mergers
12 of participants in the program under such part
13 and with respect to the inclusion of additional
14 participants in the program.

15 “(B) Issues regarding children’s hospitals,
16 and approved medical residency training pro-
17 grams in pediatrics.

18 “(C) Whether and to what extent pay-
19 ments are being made (or should be made) for
20 graduate training in the various nonphysician
21 health professions.

22 “(4) Federal policies regarding international
23 medical graduates.

24 “(5) The dependence of schools of medicine on
25 service-generated income.

1 “(6) The effects of the amendments made by
2 section 15412 of the Medicare Preservation Act of
3 1995, including adverse effects on teaching hospitals
4 that result from modifications in policies regarding
5 international medical graduates.

6 “(7) Whether and to what extent the needs of
7 the United States regarding the supply of physicians
8 will change during the 10-year period beginning on
9 October 1, 1995, and whether and to what extent
10 any such changes will have significant financial ef-
11 fects on teaching hospitals.

12 “(8) The appropriate number and mix of resi-
13 dents.

14 “(c) COMPOSITION.—Not later than three months
15 after being designated as the initial chair of the Medicare
16 Payment Review Commission, the Chair of the Commis-
17 sion shall appoint to the Panel 19 individuals who are not
18 members of the Commission, who are not officers or em-
19 ployees of the United States, and who possess expertise
20 on matters on which the Panel is to make recommenda-
21 tions under subsection (b). Such individuals shall include
22 the following:

23 “(1) Deans from allopathic and osteopathic
24 schools of medicine.

1 “(2) Chief executive officers (or equivalent ad-
2 ministrative heads) from academic health centers,
3 integrated health care systems, approved medical
4 residency training programs, and teaching hospitals
5 that sponsor approved medical residency training
6 programs.

7 “(3) Chairs of departments or divisions from
8 allopathic and osteopathic schools of medicine,
9 schools of dentistry, and approved medical residency
10 training programs in oral surgery.

11 “(4) Individuals with leadership experience
12 from each of the fields of advanced practice nursing,
13 physician assistants, and podiatric medicine.

14 “(5) Individuals with substantial experience in
15 the study of issues regarding the composition of the
16 health care workforce of the United States.

17 “(6) Individuals with expertise on the financing
18 of health care.

19 “(7) Representatives from health insurance or-
20 ganizations and health plan organizations.

21 “(d) RELATIONSHIP OF PANEL TO MEDICARE PAY-
22 MENT REVIEW COMMISSION.—From amounts appro-
23 priated under subsection (n), the Medicare Payment Re-
24 view Commission shall provide for the Panel such staff
25 and administrative support (including quarters for the

1 Panel) as may be necessary for the Panel to carry out
2 the duties under subsection (b).

3 “(e) CHAIR.—The Panel shall designate a member of
4 the Panel to serve as the Chair of the Panel.

5 “(f) MEETINGS.—The Panel shall meet at the call of
6 the Chair or a majority of the members, except that the
7 first meeting of the Panel shall be held not later than
8 three months after the date on which appointments under
9 subsection (c) are completed.

10 “(g) TERMS.—The term of a member of the Panel
11 is the duration of the Panel.

12 “(h) VACANCIES.—

13 “(1) IN GENERAL.—A vacancy in the member-
14 ship of the Panel does not affect the power of the
15 remaining members to carry out the duties under
16 subsection (b). A vacancy in the membership of the
17 Panel shall be filled in the manner in which the
18 original appointment was made.

19 “(2) INCOMPLETE TERM.—If a member of the
20 Panel does not serve the full term applicable to the
21 member, the individual appointed to fill the resulting
22 vacancy shall be appointed for the remainder of the
23 term of the predecessor of the individual.

24 “(i) COMPENSATION; REIMBURSEMENT OF EX-
25 PENSES.—

1 “(1) COMPENSATION.—Members of the Panel
2 shall receive compensation for each day (including
3 traveltime) engaged in carrying out the duties of the
4 Committee. Such compensation may not be in an
5 amount in excess of the daily equivalent of the an-
6 nual maximum rate of basic pay payable under the
7 General Schedule (under title 5, United States
8 Code) for positions above GS–15.

9 “(2) REIMBURSEMENT.—Members of the Panel
10 may, in accordance with chapter 57 of title 5, Unit-
11 ed States Code, be reimbursed for travel, subsist-
12 ence, and other necessary expenses incurred in car-
13 rying out the duties of the Panel.

14 “(j) CONSULTANTS.—The Panel may procure such
15 temporary and intermittent services of consultants under
16 section 3109(b) of title 5, United States Code, as the
17 Panel may determine to be useful in carrying out the du-
18 ties under subsection (b). The Panel may not procure serv-
19 ices under this subsection at any rate in excess of the daily
20 equivalent of the maximum annual rate of basic pay pay-
21 able under the General Schedule for positions above GS–
22 15. Consultants under this subsection may, in accordance
23 with chapter 57 of title 5, United States Code, be reim-
24 bursed for travel, subsistence, and other necessary ex-

1 penses incurred for activities carried out on behalf of the
2 Panel pursuant to subsection (b).

3 “(k) POWERS.—

4 “(1) IN GENERAL.—For the purpose of carry-
5 ing out the duties of the Panel under subsection (b),
6 the Panel may hold such hearings, sit and act at
7 such times and places, take such testimony, and re-
8 ceive such evidence as the Panel considers appro-
9 priate.

10 “(2) OBTAINING OFFICIAL INFORMATION.—

11 Upon the request of the Panel, the heads of Federal
12 agencies shall furnish directly to the Panel informa-
13 tion necessary for the Panel to carry out the duties
14 under subsection (b).

15 “(3) USE OF MAILS.—The Panel may use the
16 United States mails in the same manner and under
17 the same conditions as Federal agencies.

18 “(l) REPORTS.—

19 “(1) FIRST INTERIM REPORT.—Not later than
20 one year after the date of the enactment of the Med-
21 icare Preservation Act of 1995, the Panel shall sub-
22 mit to the Congress a report providing the rec-
23 ommendations of the Panel regarding the matters
24 specified in paragraphs (1) through (4) of subsection
25 (b).

1 “(2) SECOND INTERIM REPORT.—Not later
2 than 2 years after the date of enactment specified
3 in paragraph (1), the Panel shall submit to the Con-
4 gress a report providing the recommendations of the
5 Panel regarding the matters specified in paragraphs
6 (5) and (6) of subsection (b).

7 “(3) FINAL REPORT.—Not later than 3 years
8 after the date of enactment specified in paragraph
9 (1), the Panel shall submit to the Congress a final
10 report providing the recommendations of the Panel
11 under subsection (b).

12 “(m) DURATION.—The Panel terminates upon the
13 expiration of the 180-day period beginning on the date on
14 which the final report under subsection (l)(3) is submitted
15 to the Congress.

16 “(n) AUTHORIZATION OF APPROPRIATIONS.—

17 “(1) IN GENERAL.—Subject to paragraph (2),
18 for the purpose of carrying out this section, there
19 are authorized to be appropriated such sums as may
20 be necessary for each of the fiscal years 1996
21 through 1999.

22 “(2) LIMITATION.—The authorization of appro-
23 priations established in paragraph (1) is effective
24 only with respect to appropriations made from allo-

1 cations under section 302(b) of the Congressional
2 Budget Act of 1974—

3 “(A) for the Subcommittee on Labor,
4 Health and Human Services, and Education,
5 Committee on Appropriations of the House of
6 Representatives, in the case of any bill, resolu-
7 tion, or amendment considered in the House;
8 and

9 “(B) for the Subcommittee on Labor,
10 Health and Human Services, and Education,
11 Committee on Appropriations of the Senate, in
12 the case of any bill, resolution, or amendment
13 considered in the Senate.”.

14 **Subtitle F—Provisions Relating to**
15 **Medicare Part A**

16 **PART 1—HOSPITALS**

17 **Subpart A—General Provisions Relating to Hospitals**

18 **SEC. 15501. REDUCTIONS IN INFLATION UPDATES FOR PPS**

19 **HOSPITALS.**

20 Section 1886(b)(3)(B)(i) (42 U.S.C.
21 1395ww(b)(3)(B)(i)) is amended by striking subclauses
22 (XI), (XII), and (XIII) and inserting the following:

23 “(XI) for fiscal year 1996, the market basket
24 percentage increase minus 2.5 percentage points for
25 hospitals in all areas,

1 “(XII) for each of the fiscal years 1997 through
2 2002, the market basket percentage increase minus
3 2.0 percentage points for hospitals in all areas, and
4 “(XIII) for fiscal year 2003 and each subse-
5 quent fiscal year, the market basket percentage in-
6 crease for hospitals in all areas.”.

7 **SEC. 15502. REDUCTIONS IN DISPROPORTIONATE SHARE**
8 **PAYMENT ADJUSTMENTS.**

9 (a) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C.
10 1395ww(d)(5)(F)) is amended—

11 (1) in clause (ii), by striking “The amount”
12 and inserting “Subject to clause (ix), the amount”;
13 and

14 (2) by adding at the end the following new
15 clause:

16 “(ix) In the case of discharges occurring on or after
17 October 1, 1995, the additional payment amount other-
18 wise determined under clause (ii) shall be reduced as fol-
19 lows:

20 “(I) For discharges occurring on or after Octo-
21 ber 1, 1995, and on or before September 30, 1996,
22 by 20 percent.

23 “(II) For discharges occurring on or after Octo-
24 ber 1, 1996, and on or before September 30, 1997,
25 by 25 percent.

1 “(III) For discharges occurring on or after Oc-
2 tober 1, 1997, by 30 percent.”.

3 (b) CONFORMING AMENDMENT RELATING TO DE-
4 TERMINATION OF STANDARDIZED AMOUNTS.—Section
5 1886(d)(2)(C)(iv) (42 U.S.C. 1395ww(d)(2)(C)(iv)) is
6 amended by striking the period at the end and inserting
7 the following: “, and the Secretary shall not take into ac-
8 count any reductions in the amount of such additional
9 payments resulting from the amendments made by section
10 15502(a) of the Medicare Preservation Act of 1995.”.

11 **SEC. 15503. PAYMENTS FOR CAPITAL-RELATED COSTS FOR**
12 **INPATIENT HOSPITAL SERVICES.**

13 (a) REDUCTION IN PAYMENTS FOR PPS HOS-
14 PITALS.—

15 (1) CONTINUATION OF CURRENT REDUC-
16 TIONS.—Section 1886(g)(1)(A) (42 U.S.C.
17 1395ww(g)(1)(A)) is amended in the second sen-
18 tence—

19 (A) by striking “through 1995” and insert-
20 ing “through 2002”; and

21 (B) by inserting after “10 percent reduc-
22 tion” the following: “(or a 15 percent reduction
23 in the case of payments during fiscal years
24 1996 through 2002)”.

1 (2) REDUCTION IN BASE PAYMENT RATES.—

2 Section 1886(g)(1)(A) (42 U.S.C. 1395ww(g)(1)(A))

3 is amended by adding at the end the following new

4 sentence: “In addition to the reduction described in

5 the preceding sentence, for discharges occurring

6 after September 30, 1995, the Secretary shall reduce

7 by 7.47 percent the unadjusted standard Federal

8 capital payment rate (as described in 42 CFR

9 412.308(c), as in effect on the date of the enactment

10 of the Medicare Preservation Act of 1995) and shall

11 reduce by 8.27 percent the unadjusted hospital-spe-

12 cific rate (as described in 42 CFR 412.328(e)(1),

13 as in effect on such date of enactment).”.

14 (b) REDUCTION IN PAYMENTS FOR PPS-EXEMPT

15 HOSPITALS.—Section 1886(g) (42 U.S.C. 1395ww(g)) is

16 amended by adding at the end the following new para-

17 graph:

18 “(4)(A) Except as provided in subparagraph (B), in

19 determining the amount of the payments that may be

20 made under this title with respect to all the capital-related

21 costs of inpatient hospital services furnished during fiscal

22 years 1996 through 2002 of a hospital which is not a sub-

23 section (d) hospital or a subsection (d) Puerto Rico hos-

24 pital, the Secretary shall reduce the amounts of such pay-

25 ments otherwise determined under this title by 15 percent.

1 “(B) Subparagraph (A) shall not apply to payments
2 with respect to the capital-related costs of any hospital
3 that is a sole community hospital (as defined in subsection
4 (d)(5)(D)(iii) or a rural primary care hospital (as defined
5 in section 1861(mm)(1)).”.

6 (c) HOSPITAL-SPECIFIC ADJUSTMENT FOR CAPITAL-
7 RELATED TAX COSTS.—Section 1886(g)(1) (42 U.S.C.
8 1395ww(g)(1)) is amended—

9 (1) by redesignating subparagraph (C) as sub-
10 paragraph (D), and

11 (2) by inserting after subparagraph (B) the fol-
12 lowing:

13 “(C)(i) For discharges occurring after September 30,
14 1995, such system shall provide for an adjustment in an
15 amount equal to the amount determined under clause (iv)
16 for capital-related tax costs for each hospital that is eligi-
17 ble for such adjustment.

18 “(ii) Subject to clause (iii), a hospital is eligible for
19 an adjustment under this subparagraph, with respect to
20 discharges occurring in a fiscal year, if the hospital—

21 “(I) is a hospital that may otherwise receive
22 payments under this subsection,

23 “(II) is not a public hospital, and

24 “(III) incurs capital-related tax costs for the
25 fiscal year.

1 “(iii)(I) In the case of a hospital that first incurs cap-
 2 ital-related tax costs in a fiscal year after fiscal year 1992
 3 because of a change from nonproprietary to proprietary
 4 status or because the hospital commenced operation after
 5 such fiscal year, the first fiscal year for which the hospital
 6 shall be eligible for such adjustment is the second full fis-
 7 cal year following the fiscal year in which the hospital first
 8 incurs such costs.

9 “(II) In the case of a hospital that first incurs cap-
 10 ital-related tax costs in a fiscal year after fiscal year 1992
 11 because of a change in State or local tax laws, the first
 12 fiscal year for which the hospital shall be eligible for such
 13 adjustment is the fourth full fiscal year following the fiscal
 14 year in which the hospital first incurs such costs.

15 “(iv) The per discharge adjustment under this clause
 16 shall be equal to the hospital-specific capital-related tax
 17 costs per discharge of a hospital for fiscal year 1992 (or,
 18 in the case of a hospital that first incurs capital-related
 19 tax costs for a fiscal year after fiscal year 1992, for the
 20 first full fiscal year for which such costs are incurred),
 21 updated to the fiscal year to which the adjustment applies.
 22 Such per discharge adjustment shall be added to the Fed-
 23 eral capital rate, after such rate has been adjusted as de-
 24 scribed in 42 CFR 412.312 (as in effect on the date of
 25 the enactment of the Medicare Preservation Act of 1995),

1 and before such rate is multiplied by the applicable Fed-
2 eral rate percentage.

3 “(v) For purposes of this subparagraph, capital-relat-
4 ed tax costs include—

5 “(I) the costs of taxes on land and depreciable
6 assets owned by a hospital (or related organization)
7 and used for patient care,

8 “(II) payments in lieu of such taxes (made by
9 hospitals that are exempt from taxation), and

10 “(III) the costs of taxes paid by a hospital (or
11 related organization) as lessee of land, buildings, or
12 fixed equipment from a lessor that is unrelated to
13 the hospital (or related organization) under the
14 terms of a lease that requires the lessee to pay all
15 expenses (including mortgage, interest, and amorti-
16 zation) and leaves the lessor with an amount free of
17 all claims (sometimes referred to as a ‘net net net’
18 or ‘triple net’ lease).

19 In determining the adjustment required under clause (i),
20 the Secretary shall not take into account any capital-relat-
21 ed tax costs of a hospital to the extent that such costs
22 are based on tax rates and assessments that exceed those
23 for similar commercial properties.

24 “(vi) The system shall provide that the Federal cap-
25 ital rate for any fiscal year after September 30, 1995,

1 shall be reduced by a percentage sufficient to ensure that
 2 the adjustments required to be paid under clause (i) for
 3 a fiscal year neither increase nor decrease the total
 4 amount that would have been paid under this system but
 5 for the payment of such adjustments for such fiscal year.”.

6 (d) REVISION OF EXCEPTIONS PROCESS UNDER
 7 PROSPECTIVE PAYMENT SYSTEM FOR CERTAIN
 8 PROJECTS.—

9 (1) IN GENERAL.—Section 1886(g)(1) (42
 10 U.S.C. 1395ww(g)(1)), as amended by subsection
 11 (c), is amended—

12 (A) by redesignating subparagraph (D) as
 13 subparagraph (E), and

14 (B) by inserting after subparagraph (C)
 15 the following:

16 “(D) The exceptions under the system provided by
 17 the Secretary under subparagraph (B)(iii) shall include
 18 the provision of exception payments under the special ex-
 19 ceptions process provided under 42 CFR 412.348(g) (as
 20 in effect on September 1, 1995), except that the Secretary
 21 shall revise such process as follows:

22 “(i) A hospital with at least 100 beds which is
 23 located in an urban area shall be eligible under such
 24 process without regard to its disproportionate pa-
 25 tient percentage under subsection (d)(5)(F) or

1 whether it qualifies for additional payment amounts
2 under such subsection.

3 “(ii) The minimum payment level for qualifying
4 hospitals shall be 85 percent.

5 “(iii) A hospital shall be considered to meet the
6 requirement that it completes the project involved no
7 later than the end of the hospital’s last cost report-
8 ing period beginning after October 1, 2001, if—

9 “(I) the hospital has obtained a certificate
10 of need for the project approved by the State or
11 a local planning authority, and

12 “(II) by September 1, 1995, the hospital
13 has expended on the project at least \$750,000
14 or 10 percent of the estimated cost of the
15 project.

16 “(iv) The amount of the exception payment
17 made shall not be reduced by any offsetting
18 amounts.”.

19 (2) CONFORMING AMENDMENT.—Section
20 1886(g)(1)(B)(iii) (42 U.S.C. 1395ww(g)(1)(B)(iii))
21 is amended by striking “may provide” and inserting
22 “shall provide (in accordance with subparagraph
23 (D))”.

1 **SEC. 15504. REDUCTION IN ADJUSTMENT FOR INDIRECT**
 2 **MEDICAL EDUCATION.**

3 For provisions modifying medicare payment policies
 4 regarding graduate medical education, see part 2 of sub-
 5 title E.

6 **SEC. 15505. TREATMENT OF PPS-EXEMPT HOSPITALS.**

7 (a) UPDATES.—Section 1886(b)(3)(B)(ii)(V) (42
 8 U.S.C. 1395ww(b)(3)(B)(ii)(V)) is amended by striking
 9 “thorough 1997” and inserting “through 2002”.

10 (b) REBASING FOR CERTAIN LONG-TERM CARE HOS-
 11 PITALS.—

12 (1) IN GENERAL.—Section 1886(b)(3) (42
 13 U.S.C. 1395ww(b)(3)) is amended—

14 (A) in subparagraph (A), by striking “and
 15 (E)” and inserting “(E), and (F)”;

16 (B) in subparagraph (B)(ii), by striking
 17 “(A) and (E)” and inserting “(A), (E), and
 18 (F)”; and

19 (C) by adding at the end the following new
 20 subparagraph:

21 “(F)(i) In the case of a qualified long-term care hos-
 22 pital (as defined in clause (ii)), the term ‘target amount’
 23 means—

24 “(I) with respect to the first 12-month cost re-
 25 porting period in which this subparagraph is applied
 26 to the hospital, the allowable operating costs of inpa-

1 tient hospital services (as defined in subsection
2 (a)(4)) recognized under this title for the hospital
3 for the 12-month cost reporting period beginning
4 during fiscal year 1991; or

5 “(II) with respect to a later cost reporting pe-
6 riod, the target amount for the preceding cost re-
7 porting period, increase by the applicable percentage
8 increase under subparagraph (B)(ii) for that later
9 cost reporting period.

10 “(ii) In clause (i), a ‘qualified long-term care hospital’
11 means, with respect to a cost reporting period, a hospital
12 described in clause (iv) of subsection (d)(1)(B) during fis-
13 cal year 1995 for which the hospital’s allowable operating
14 costs of inpatient hospital services recognized under this
15 title for each of the two most recent previous 12-month
16 cost reporting periods exceeded the hospital’s target
17 amount determined under this paragraph for such cost re-
18 porting periods, if the hospital—

19 “(I) has a disproportionate patient percentage
20 during such cost reporting period (as determined by
21 the Secretary under subsection (d)(5)(F)(vi) as if
22 the hospital were a subsection (d) hospital) of at
23 least 25 percent, or

24 “(II) is located in a State for which no payment
25 is made under the State plan under title XIX for

1 days of inpatient hospital services furnished to any
2 individual in excess of the limit on the number of
3 days of such services furnished to the individual for
4 which payment may be made under this title.”.

5 (2) EFFECTIVE DATE.—The amendment made
6 by paragraph (1) shall apply to discharges occurring
7 during cost reporting periods beginning on or after
8 October 1, 1995.

9 (c) TREATMENT OF CERTAIN LONG-TERM CARE
10 HOSPITALS LOCATED WITHIN OTHER HOSPITALS.—

11 (1) IN GENERAL.—Section 1886(d)(1)(B) (42
12 U.S.C. 1395ww(d)(1)(B)) is amended in the matter
13 following clause (v) by striking the period and in-
14 serting the following: “, or a hospital classified by
15 the Secretary as a long-term care hospital on or be-
16 fore September 30, 1995, and located in the same
17 building as, or on the same campus as, another hos-
18 pital.”.

19 (2) STUDY BY REVIEW COMMISSION.—Not later
20 than 12 months after the date a majority of the
21 members of the Medicare Payment Review Commis-
22 sion are first appointed, the Commission shall sub-
23 mit a report to Congress containing recommenda-
24 tions for appropriate revisions in the treatment of
25 long-term care hospitals located in the same building

1 as or on the same campus as another hospital for
2 purposes of section 1886 of the Social Security Act.

3 (3) EFFECTIVE DATE.—The amendment made
4 by paragraph (1) shall apply to discharges occurring
5 on or after October 1, 1995.

6 (d) STUDY OF PROSPECTIVE PAYMENT SYSTEM FOR
7 REHABILITATION HOSPITALS AND UNITS.—

8 (1) IN GENERAL.—After consultation with the
9 Prospective Payment Assessment Commission, pro-
10 viders of rehabilitation services, and other appro-
11 priate parties, the Secretary of Health and Human
12 Services shall submit to Congress, by not later than
13 June 1, 1996, a report on the advisability and fea-
14 sibility of providing for payment based on a prospec-
15 tive payment system for inpatient services of reha-
16 bilitation hospitals and units under the medicare
17 program.

18 (2) ITEMS INCLUDED.—The report shall include
19 the following:

20 (A) The available and preferred systems of
21 classifying rehabilitation patients relative to du-
22 ration and intensity of inpatient services, in-
23 cluding the use of functional-related groups
24 (FRGs).

1 (B) The means of calculating medicare
2 program payments to reflect such patient re-
3 quirements.

4 (C) Other appropriate adjustments which
5 should be made, such as for geographic vari-
6 ations in wages and other costs and outliers.

7 (D) A timetable under which such a sys-
8 tem might be introduced.

9 (E) Whether such a system should be ap-
10 plied to other types of providers of inpatient re-
11 habilitation services.

12 **SEC. 15506. REDUCTION IN PAYMENTS TO HOSPITALS FOR**
13 **ENROLLEES' BAD DEBTS.**

14 (a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C.
15 1395x(v)(1)) is amended by adding at the end the follow-
16 ing new subparagraph:

17 “(T)(i) In determining such reasonable costs for hos-
18 pitals, the amount of bad debts otherwise treated as allow-
19 able costs which are attributable to the deductibles and
20 coinsurance amounts under this title shall be reduced by—

21 “(I) 75 percent for cost reporting periods begin-
22 ning during fiscal year 1996,

23 “(II) 60 percent for cost reporting periods be-
24 ginning during fiscal year 1997, and

1 “(III) 50 percent for subsequent cost reporting
2 periods.

3 “(ii) Clause (i) shall not apply with respect to bad
4 debt of a hospital described in section 1886(d)(1)(B)(iv)
5 if the debt is attributable to uncollectable deductible and
6 coinsurance payments owed by individuals enrolled in a
7 State plan under title XIX or under the MediGrant pro-
8 gram under title XXI.”.

9 (b) EFFECTIVE DATE.—The amendment made by
10 subsection (a) shall apply to hospital cost reporting peri-
11 ods beginning on or after October 1, 1995.

12 **SEC. 15507. PERMANENT EXTENSION OF HEMOPHILIA PASS-**
13 **THROUGH.**

14 Effective as if included in the enactment of OBRA—
15 1989, section 6011(d) of such Act (as amended by section
16 13505 of OBRA–1993) is amended by striking “and shall
17 expire September 30, 1994”.

18 **SEC. 15508. CONFORMING AMENDMENT TO CERTIFICATION**
19 **OF CHRISTIAN SCIENCE PROVIDERS.**

20 (a) HOSPITALS.—Section 1861(e) (42 U.S.C.
21 1395x(e)) is amended in the sixth sentence by inserting
22 after “Massachusetts,” the following: “or by the Commis-
23 sion for Accreditation of Christian Science Nursing Orga-
24 nizations/Facilities, Inc.,”.

(b) SKILLED NURSING FACILITIES.—Section 1861(y)(1) is amended by inserting after “Massachusetts,” the following: “or by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.,”.

Subpart B—Provisions Relating to Rural Hospitals

SEC. 15511. SOLE COMMUNITY HOSPITALS.

(a) UPDATE.—Section 1886(b)(3)(B)(iv) (42 U.S.C. 1395ww(b)(3)(B)(iv)) is amended—

(A) in subclause (III), by striking “and” at the end; and

(B) by striking subclause (IV) and inserting the following:

“(IV) for each of the fiscal years 1996 through 2000, the market basket percentage increase minus 1 percentage points, and

“(V) for fiscal year 2001 and each subsequent fiscal year, the applicable percentage increase under clause (i).”.

(b) STUDY OF IMPACT OF SOLE COMMUNITY HOSPITAL DESIGNATIONS.—

(1) STUDY.—The Medicare Payment Review Commission shall conduct a study of the impact of the designation of hospitals as sole community hospitals under the medicare program on the delivery of

1 health care services to individuals in rural areas, and
 2 shall include in the study an analysis of the charac-
 3 teristics of the hospitals designated as such sole
 4 community hospitals under the program.

5 (2) REPORT.—Not later than 12 months after
 6 the date a majority of the members of the Commis-
 7 sion are first appointed, the Commission shall sub-
 8 mit to Congress a report on the study conducted
 9 under paragraph (1).

10 **SEC. 15512. CLARIFICATION OF TREATMENT OF EAC AND**
 11 **RPC HOSPITALS.**

12 Paragraphs (1)(A)(i) and (2)(A)(i) of section 1820(i)
 13 (42 U.S.C. 1395i–4(i)) are each amended by striking the
 14 semicolon at the end and inserting the following: “, or in
 15 a State which the Secretary finds would receive a grant
 16 under such subsection during a fiscal year if funds were
 17 appropriated for grants under such subsection for the fis-
 18 cal year;”.

19 **SEC. 15513. ESTABLISHMENT OF RURAL EMERGENCY AC-**
 20 **CESS CARE HOSPITALS.**

21 (a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x)
 22 is amended by adding at the end the following new sub-
 23 section:

1 “Rural Emergency Access Care Hospital; Rural
2 Emergency Access Care Hospital Services

3 “(oo)(1) The term ‘rural emergency access care hos-
4 pital’ means, for a fiscal year, a facility with respect to
5 which the Secretary finds the following:

6 “(A) The facility is located in a rural area (as
7 defined in section 1886(d)(2)(D)).

8 “(B) The facility was a hospital under this title
9 at any time during the 5-year period that ends on
10 the date of the enactment of this subsection.

11 “(C) The facility is in danger of closing due to
12 low inpatient utilization rates and operating losses,
13 and the closure of the facility would limit the access
14 to emergency services of individuals residing in the
15 facility’s service area.

16 “(D) The facility has entered into (or plans to
17 enter into) an agreement with a hospital with a par-
18 ticipation agreement in effect under section 1866(a),
19 and under such agreement the hospital shall accept
20 patients transferred to the hospital from the facility
21 and receive data from and transmit data to the facil-
22 ity.

23 “(E) There is a practitioner who is qualified to
24 provide advanced cardiac life support services (as de-

1 terminated by the State in which the facility is lo-
2 cated) on-site at the facility on a 24-hour basis.

3 “(F) A physician is available on-call to provide
4 emergency medical services on a 24-hour basis.

5 “(G) The facility meets such staffing require-
6 ments as would apply under section 1861(e) to a
7 hospital located in a rural area, except that—

8 “(i) the facility need not meet hospital
9 standards relating to the number of hours dur-
10 ing a day, or days during a week, in which the
11 facility must be open, except insofar as the fa-
12 cility is required to provide emergency care on
13 a 24-hour basis under subparagraphs (E) and
14 (F); and

15 “(ii) the facility may provide any services
16 otherwise required to be provided by a full-time,
17 on-site dietitian, pharmacist, laboratory techni-
18 cian, medical technologist, or radiological tech-
19 nologist on a part-time, off-site basis.

20 “(H) The facility meets the requirements appli-
21 cable to clinics and facilities under subparagraphs
22 (C) through (J) of paragraph (2) of section
23 1861(aa) and of clauses (ii) and (iv) of the second
24 sentence of such paragraph (or, in the case of the
25 requirements of subparagraph (E), (F), or (J) of

1 such paragraph, would meet the requirements if any
 2 reference in such subparagraph to a ‘nurse practi-
 3 tioner’ or to ‘nurse practitioners’ were deemed to be
 4 a reference to a ‘nurse practitioner or nurse’ or to
 5 ‘nurse practitioners or nurses’); except that in deter-
 6 mining whether a facility meets the requirements of
 7 this subparagraph, subparagraphs (E) and (F) of
 8 that paragraph shall be applied as if any reference
 9 to a ‘physician’ is a reference to a physician as de-
 10 fined in section 1861(r)(1).

11 “(2) The term ‘rural emergency access care hospital
 12 services’ means the following services provided by a rural
 13 emergency access care hospital and furnished to an indi-
 14 vidual over a continuous period not to exceed 24 hours
 15 (except that such services may be furnished over a longer
 16 period in the case of an individual who is unable to leave
 17 the hospital because of inclement weather):

18 “(A) An appropriate medical screening exam-
 19 ination (as described in section 1867(a)).

20 “(B) Necessary stabilizing examination and
 21 treatment services for an emergency medical condi-
 22 tion and labor (as described in section 1867(b)).”.

23 (b) REQUIRING RURAL EMERGENCY ACCESS CARE
 24 HOSPITALS TO MEET HOSPITAL ANTI-DUMPING RE-
 25 QUIREMENTS.—Section 1867(e)(5) (42 U.S.C.

1 1395dd(e)(5)) is amended by striking “1861(mm)(1))”
 2 and inserting “1861(mm)(1)) and a rural emergency ac-
 3 cess care hospital (as defined in section 1861(oo)(1))”.

4 (c) REFERENCE TO PAYMENT PROVISIONS UNDER
 5 PART B.—For provisions relating to payment for rural
 6 emergency access care hospital services under part B, see
 7 section 15607.

8 (d) EFFECTIVE DATE.—The amendments made by
 9 this section shall apply to fiscal years beginning on or
 10 after October 1, 1995.

11 **SEC. 15514. CLASSIFICATION OF RURAL REFERRAL CEN-**
 12 **TERS.**

13 (a) PROHIBITING DENIAL OF REQUEST FOR RECLAS-
 14 SIFICATION ON BASIS OF COMPARABILITY OF WAGES.—

15 (1) IN GENERAL.—Section 1886(d)(10)(D) (42
 16 U.S.C. 1395ww(d)(10)(D)) is amended—

17 (A) by redesignating clause (iii) as clause
 18 (iv); and

19 (B) by inserting after clause (ii) the follow-
 20 ing new clause:

21 “(iii) Under the guidelines published by the Secretary
 22 under clause (i), in the case of a hospital which is classi-
 23 fied by the Secretary as a rural referral center under para-
 24 graph (5)(C), the Board may not reject the application
 25 of the hospital under this paragraph on the basis of any

1 comparison between the average hourly wage of the hos-
 2 pital and the average hourly wage of hospitals in the area
 3 in which it is located.”.

4 (2) EFFECTIVE DATE.—Notwithstanding sec-
 5 tion 1886(d)(10)(C)(ii) of the Social Security Act, a
 6 hospital may submit an application to the Medicare
 7 Geographic Classification Review Board during the
 8 30-day period beginning on the date of the enact-
 9 ment of this Act requesting a change in its classi-
 10 fication for purposes of determining the area wage
 11 index applicable to the hospital under section
 12 1886(d)(3)(D) of such Act for fiscal year 1997, if
 13 the hospital would be eligible for such a change in
 14 its classification under the standards described in
 15 section 1886(d)(10)(D) (as amended by paragraph
 16 (1)) but for its failure to meet the deadline for appli-
 17 cations under section 1886(d)(10)(C)(ii).

18 (b) CONTINUING TREATMENT OF PREVIOUSLY DES-
 19 IGNATED CENTERS.—Any hospital classified as a rural re-
 20 ferral center by the Secretary of Health and Human Serv-
 21 ices under section 1886(d)(5)(C) of the Social Security
 22 Act for fiscal year 1994 shall be classified as such a rural
 23 referral center for fiscal year 1996 and each subsequent
 24 fiscal year.

1 **SEC. 15515. FLOOR ON AREA WAGE INDEX.**

2 (a) IN GENERAL.—For purposes of section
 3 1886(d)(3)(E) of the Social Security Act for discharges
 4 occurring on or after October 1, 1995, the area wage index
 5 applicable under such section to any hospital which is not
 6 located in a rural area (as defined in section
 7 1886(d)(2)(D) of such Act) may not be less than the aver-
 8 age of the area wage indices applicable under such section
 9 to hospitals located in rural areas in the State in which
 10 the hospital is located.

11 (b) BUDGET-NEUTRALITY IN IMPLEMENTATION.—
 12 The Secretary of Health and Human Services shall adjust
 13 the area wage indices referred to in subsection (a) for hos-
 14 pitals not described in such subsection in a manner which
 15 assures that the aggregate payments made under section
 16 1886(d) of the Social Security Act in a fiscal year for the
 17 operating costs of inpatient hospital services are not great-
 18 er or less than those which would have been made in the
 19 year if this section did not apply.

20 **PART 2—PAYMENTS TO SKILLED NURSING**

21 **FACILITIES**

22 **SEC. 15521. PAYMENTS FOR ROUTINE SERVICE COSTS.**

23 (a) CLARIFICATION OF DEFINITION OF ROUTINE
 24 SERVICE COSTS.—Section 1888 (42 U.S.C. 1395yy) is
 25 amended by adding at the end the following new sub-
 26 section:

1 “(e) For purposes of this section, the ‘routine service
2 costs’ of a skilled nursing facility are all costs which are
3 attributable to nursing services, room and board, adminis-
4 trative costs, other overhead costs, and all other ancillary
5 services (including supplies and equipment), excluding
6 costs attributable to covered non-routine services subject
7 to payment limits under section 1888A.”.

8 (b) CONFORMING AMENDMENT.—Section 1888 (42
9 U.S.C. 1395yy) is amended in the heading by inserting
10 “AND CERTAIN ANCILLARY” after “SERVICE”.

11 **SEC. 15522. INCENTIVES FOR COST EFFECTIVE MANAGE-**
12 **MENT OF COVERED NON-ROUTINE SERVICES.**

13 (a) IN GENERAL.—Title XVIII is amended by insert-
14 ing after section 1888 the following new section:

15 “INCENTIVES FOR COST-EFFECTIVE MANAGEMENT OF
16 COVERED NON-ROUTINE SERVICES OF SKILLED
17 NURSING FACILITIES

18 “SEC. 1888A. (a) DEFINITIONS.—For purposes of
19 this section:

20 “(1) COVERED NON-ROUTINE SERVICES.—The
21 term ‘covered non-routine services’ means post-hos-
22 pital extended care services consisting of any of the
23 following:

24 “(A) Physical or occupational therapy or
25 speech-language pathology services, or res-

1 piratory therapy, including supplies and support
2 services incident to such services and therapy.

3 “(B) Prescription drugs.

4 “(C) Complex medical equipment.

5 “(D) Intravenous therapy and solutions
6 (including enteral and parenteral nutrients,
7 supplies, and equipment).

8 “(E) Radiation therapy.

9 “(F) Diagnostic services, including labora-
10 tory, radiology (including computerized tomog-
11 raphy services and imaging services), and pul-
12 monary services.

13 “(2) SNF MARKET BASKET PERCENTAGE IN-
14 CREASE.—The term ‘SNF market basket percentage
15 increase’ for a fiscal year means a percentage equal
16 to the percentage increase in routine service cost
17 limits for the year under section 1888(a).

18 “(3) STAY.—The term ‘stay’ means, with re-
19 spect to an individual who is a resident of a skilled
20 nursing facility, a period of continuous days during
21 which the facility provides extended care services for
22 which payment may be made under this title with
23 respect to the individual during the individual’s spell
24 of illness.

1 “(b) NEW PAYMENT METHOD FOR COVERED NON-
2 ROUTINE SERVICES.—

3 “(1) IN GENERAL.—Subject to subsection (c), a
4 skilled nursing facility shall receive interim pay-
5 ments under this title for covered non-routine serv-
6 ices furnished to an individual during a cost report-
7 ing period beginning during a fiscal year (after fiscal
8 year 1996) in an amount equal to the reasonable
9 cost of providing such services in accordance with
10 section 1861(v). The Secretary may adjust such pay-
11 ments if the Secretary determines (on the basis of
12 such estimated information as the Secretary consid-
13 ers appropriate) that payments to the facility under
14 this paragraph for a cost reporting period would
15 substantially exceed the cost reporting period limit
16 determined under subsection (c)(1)(B).

17 “(2) RESPONSIBILITY OF SKILLED NURSING
18 FACILITY TO MANAGE BILLINGS.—

19 “(A) CLARIFICATION RELATING TO PART A
20 BILLING.—In the case of a covered non-routine
21 service furnished to an individual who (at the
22 time the service is furnished) is a resident of a
23 skilled nursing facility who is entitled to cov-
24 erage under section 1812(a)(2) for such service,
25 the skilled nursing facility shall submit a claim

1 for payment under this title for such service
 2 under part A (without regard to whether or not
 3 the item or service was furnished by the facility,
 4 by others under arrangement with them made
 5 by the facility, under any other contracting or
 6 consulting arrangement, or otherwise).

7 “(B) PART B BILLING.—In the case of a
 8 covered non-routine service (other than a port-
 9 able X-ray or portable electrocardiogram treat-
 10 ed as a physician’s service for purposes of sec-
 11 tion 1848(j)(3)) furnished to an individual who
 12 (at the time the service is furnished) is a resi-
 13 dent of a skilled nursing facility who is not enti-
 14 tled to coverage under section 1812(a)(2) for
 15 such service but is entitled to coverage under
 16 part B for such service, the skilled nursing fa-
 17 cility shall submit a claim for payment under
 18 this title for such service under part B (without
 19 regard to whether or not the item or service
 20 was furnished by the facility, by others under
 21 arrangement with them made by the facility,
 22 under any other contracting or consulting ar-
 23 rangement, or otherwise).

24 “(C) MAINTAINING RECORDS ON SERVICES
 25 FURNISHED TO RESIDENTS.—Each skilled nurs-

1 ing facility receiving payments for extended
2 care services under this title shall document on
3 the facility's cost report all covered non-routine
4 services furnished to all residents of the facility
5 to whom the facility provided extended care
6 services for which payment was made under
7 part A during a fiscal year (beginning with fis-
8 cal year 1996) (without regard to whether or
9 not the services were furnished by the facility,
10 by others under arrangement with them made
11 by the facility, under any other contracting or
12 consulting arrangement, or otherwise).

13 “(c) RECONCILIATION OF AMOUNTS.—

14 “(1) LIMIT BASED ON PER STAY LIMIT AND
15 NUMBER OF STAYS.—

16 “(A) IN GENERAL.—If a skilled nursing fa-
17 cility has received aggregate payments under
18 subsection (b) for covered non-routine services
19 during a cost reporting period beginning during
20 a fiscal year in excess of an amount equal to
21 the cost reporting period limit determined
22 under subparagraph (B), the Secretary shall re-
23 duce the payments made to the facility with re-
24 spect to such services for cost reporting periods
25 beginning during the following fiscal year in an

1 amount equal to such excess. The Secretary
2 shall reduce payments under this subparagraph
3 at such times and in such manner during a fis-
4 cal year as the Secretary finds necessary to
5 meet the requirement of this subparagraph.

6 “(B) COST REPORTING PERIOD LIMIT.—
7 The cost reporting period limit determined
8 under this subparagraph is an amount equal to
9 the product of—

10 “(i) the per stay limit applicable to
11 the facility under subsection (d) for the pe-
12 riod; and

13 “(ii) the number of stays beginning
14 during the period for which payment was
15 made to the facility for such services.

16 “(C) PROSPECTIVE REDUCTION IN PAY-
17 MENTS.—In addition to the process for reduc-
18 ing payments described in subparagraph (A),
19 the Secretary may reduce payments made to a
20 facility under this section during a cost report-
21 ing period if the Secretary determines (on the
22 basis of such estimated information as the Sec-
23 retary considers appropriate) that payments to
24 the facility under this section for the period will
25 substantially exceed the cost reporting period

1 limit for the period determined under this para-
2 graph.

3 “(2) INCENTIVE PAYMENTS.—

4 “(A) IN GENERAL.—If a skilled nursing fa-
5 cility has received aggregate payments under
6 subsection (b) for covered non-routine services
7 during a cost reporting period beginning during
8 a fiscal year in an amount that is less than the
9 amount determined under paragraph (1)(B),
10 the Secretary shall pay the skilled nursing facil-
11 ity in the following fiscal year an incentive pay-
12 ment equal to 50 percent of the difference be-
13 tween such amounts, except that the incentive
14 payment may not exceed 5 percent of the aggre-
15 gate payments made to the facility under sub-
16 section (b) for the previous fiscal year (without
17 regard to subparagraph (B)).

18 “(B) INSTALLMENT INCENTIVE PAY-
19 MENTS.—The Secretary may make installment
20 payments during a fiscal year to a skilled nurs-
21 ing facility based on the estimated incentive
22 payment that the facility would be eligible to re-
23 ceive with respect to such fiscal year.

24 “(d) DETERMINATION OF FACILITY PER STAY
25 LIMIT.—

1 “(1) LIMIT FOR FISCAL YEAR 1997.—

2 “(A) IN GENERAL.—Except as provided in
3 subparagraph (B), the Secretary shall establish
4 separate per stay limits for hospital-based and
5 freestanding skilled nursing facilities for the 12-
6 month cost reporting period beginning during
7 fiscal year 1997 that are equal to the sum of—

8 “(i) 50 percent of the facility-specific
9 stay amount for the facility (as determined
10 under subsection (e)) for the last 12-month
11 cost reporting period ending on or before
12 September 30, 1994, increased (in a
13 compounded manner) by the SNF market
14 basket percentage increase for fiscal years
15 1995 through 1997; and

16 “(ii) 50 percent of the average of all
17 facility-specific stay amounts for all hos-
18 pital-based facilities or all freestanding fa-
19 cilities (whichever is applicable) during the
20 cost reporting period described in clause
21 (i), increased (in a compounded manner)
22 by the SNF market basket percentage in-
23 crease for fiscal years 1995 through 1997.

24 “(B) FACILITIES NOT HAVING 1994 COST
25 REPORTING PERIOD.—In the case of a skilled

1 nursing facility for which payments were not
 2 made under this title for covered non-routine
 3 services for the last 12-month cost reporting pe-
 4 riod ending on or before September 30, 1994,
 5 the per stay limit for the 12-month cost report-
 6 ing period beginning during fiscal year 1997
 7 shall be twice the amount determined under
 8 subparagraph (A)(ii).

9 “(2) LIMIT FOR SUBSEQUENT FISCAL YEARS.—

10 The per stay limit for a skilled nursing facility for
 11 a 12-month cost reporting period beginning during
 12 a fiscal year after fiscal year 1997 is equal to the
 13 per stay limit established under this subsection for
 14 the 12-month cost reporting period beginning during
 15 the previous fiscal year, increased by the SNF mar-
 16 ket basket percentage increase for such subsequent
 17 fiscal year minus 2 percentage points.

18 “(3) REBASING OF AMOUNTS.—

19 “(A) IN GENERAL.—The Secretary shall
 20 provide for an update to the facility-specific
 21 amounts used to determine the per stay limits
 22 under this subsection for cost reporting periods
 23 beginning on or after October 1, 1999, and
 24 every 2 years thereafter.

1 “(B) TREATMENT OF FACILITIES NOT
 2 HAVING REBASED COST REPORTING PERIODS.—
 3 Paragraph (1)(B) shall apply with respect to a
 4 skilled nursing facility for which payments were
 5 not made under this title for covered non-rou-
 6 tine services for the 12-month cost reporting
 7 period used by the Secretary to update facility-
 8 specific amounts under subparagraph (A) in the
 9 same manner as such paragraph applies with
 10 respect to a facility for which payments were
 11 not made under this title for covered non-rou-
 12 tine services for the last 12-month cost report-
 13 ing period ending on or before September 30,
 14 1994.

15 “(e) DETERMINATION OF FACILITY-SPECIFIC STAY
 16 AMOUNTS.—The ‘facility-specific stay amount’ for a
 17 skilled nursing facility for a cost reporting period is the
 18 sum of—

19 “(1) the average amount of payments made to
 20 the facility under part A during the period which are
 21 attributable to covered non-routine services fur-
 22 nished during a stay; and

23 “(2) the Secretary’s best estimate of the aver-
 24 age amount of payments made under part B during
 25 the period for covered non-routine services furnished

1 to all residents of the facility to whom the facility
 2 provided extended care services for which payment
 3 was made under part A during the period (without
 4 regard to whether or not the services were furnished
 5 by the facility, by others under arrangement with
 6 them made by the facility, under any other contract-
 7 ing or consulting arrangement, or otherwise), as es-
 8 timated by the Secretary.

9 “(f) INTENSIVE NURSING OR THERAPY NEEDS.—

10 “(1) IN GENERAL.—In applying subsection (b)
 11 to covered non-routine services furnished during a
 12 stay beginning during a cost reporting period begin-
 13 ning during a fiscal year to a resident of a skilled
 14 nursing facility who requires intensive nursing or
 15 therapy services, the per stay limit determined for
 16 the fiscal year under the methodology for such resi-
 17 dent shall be the per stay limit developed under
 18 paragraph (2) instead of the per stay limit deter-
 19 mined under subsection (d)(1)(A).

20 “(2) PER STAY LIMIT FOR INTENSIVE NEED
 21 RESIDENTS.—Not later than June 30, 1996, the
 22 Secretary, after consultation with the Medicare Pay-
 23 ment Review Commission and skilled nursing facility
 24 experts, shall develop and publish a methodology for
 25 determining on an annual basis a per stay limit for

1 residents of a skilled nursing facility who require in-
2 tensive nursing or therapy services.

3 “(3) BUDGET NEUTRALITY.—The Secretary
4 shall adjust payments under subsection (b) in a
5 manner that ensures that total payments for covered
6 non-routine services under this section are not great-
7 er or less than total payments for such services
8 would have been but for the application of para-
9 graph (1).

10 “(g) SPECIAL TREATMENT FOR MEDICARE LOW
11 VOLUME SKILLED NURSING FACILITIES.—This section
12 shall not apply with respect to a skilled nursing facility
13 for which payment is made for routine service costs during
14 a cost reporting period on the basis of prospective pay-
15 ments under section 1888(d).

16 “(h) EXCEPTIONS AND ADJUSTMENTS TO LIMITS.—

17 “(1) IN GENERAL.—The Secretary may make
18 exceptions and adjustments to the cost reporting
19 limits applicable to a skilled nursing facility under
20 subsection (c)(1)(B) for a cost reporting period, ex-
21 cept that the total amount of any additional pay-
22 ments made under this section for covered non-rou-
23 tine services during the cost reporting period as a
24 result of such exceptions and adjustments may not
25 exceed 5 percent of the aggregate payments made to

1 all skilled nursing facilities for covered non-routine
2 services during the cost reporting period (determined
3 without regard to this paragraph).

4 “(2) BUDGET NEUTRALITY.—The Secretary
5 shall adjust payments under subsection (b) in a
6 manner that ensures that total payments for covered
7 non-routine services under this section are not great-
8 er or less than total payments for such services
9 would have been but for the application of para-
10 graph (1).

11 “(i) SPECIAL RULE FOR X-RAY SERVICES.—Before
12 furnishing a covered non-routine service consisting of an
13 X-ray service for which payment may be made under part
14 A or part B to a resident, a skilled nursing facility shall
15 consider whether furnishing the service through a provider
16 of portable X-ray service services would be appropriate,
17 taking into account the cost effectiveness of the service
18 and the convenience to the resident.”.

19 (b) CONFORMING AMENDMENT.—Section 1814(b)
20 (42 U.S.C. 1395f(b)) is amended in the matter preceding
21 paragraph (1) by striking “1813 and 1886” and inserting
22 “1813, 1886, 1888, and 1888A”.

23 **SEC. 15523. PAYMENTS FOR ROUTINE SERVICE COSTS.**

24 (a) MAINTAINING SAVINGS RESULTING FROM TEM-
25 PORARY FREEZE ON PAYMENT INCREASES.—

1 (1) BASING UPDATES TO PER DIEM COST LIM-
2 ITS ON LIMITS FOR FISCAL YEAR 1993.—

3 (A) IN GENERAL.—The last sentence of
4 section 1888(a) (42 U.S.C. 1395yy(a)) is
5 amended by inserting before the period at the
6 end the following: “(except that such updates
7 may not take into account any changes in the
8 routine service costs of skilled nursing facilities
9 occurring during cost reporting periods which
10 began during fiscal year 1994 or fiscal year
11 1995)”.

12 (B) NO EXCEPTIONS PERMITTED BASED
13 ON AMENDMENT.—The Secretary of Health and
14 Human Services shall not consider the amend-
15 ment made by subparagraph (A) in making any
16 adjustments pursuant to section 1888(c) of the
17 Social Security Act.

18 (2) PAYMENTS DETERMINED ON PROSPECTIVE
19 BASIS.—Any change made by the Secretary of
20 Health and Human Services in the amount of any
21 prospective payment paid to a skilled nursing facility
22 under section 1888(d) of the Social Security Act for
23 cost reporting periods beginning on or after October
24 1, 1995, may not take into account any changes in
25 the costs of services occurring during cost reporting

1 periods which began during fiscal year 1994 or fiscal
2 year 1995.

3 (b) ESTABLISHMENT OF SCHEDULE FOR MAKING
4 ADJUSTMENTS TO LIMITS.—Section 1888(c) (42 U.S.C.
5 1395yy(c)) is amended by striking the period at the end
6 of the second sentence and inserting “, and may only make
7 adjustments under this subsection with respect to a facil-
8 ity which applies for an adjustment during an annual ap-
9 plication period established by the Secretary.”.

10 (c) LIMITATION ON AGGREGATE INCREASE IN PAY-
11 MENTS RESULTING FROM ADJUSTMENTS TO LIMITS.—
12 Section 1888(c) (42 U.S.C. 1395yy(c)) is amended—

13 (1) by striking “(c) The Secretary” and insert-
14 ing “(c)(1) Subject to paragraph (2), the Sec-
15 retary”; and

16 (2) by adding at the end the following new
17 paragraph:

18 “(2) The Secretary may not make any adjustments
19 under this subsection in the limits set forth in subsection
20 (a) for a cost reporting period beginning during a fiscal
21 year to the extent that the total amount of the additional
22 payments made under this title as a result of such adjust-
23 ments is greater than an amount equal to—

24 “(A) for cost reporting periods beginning dur-
25 ing fiscal year 1997, the total amount of the addi-

1 tional payments made under this title as a result of
 2 adjustments under this subsection for cost reporting
 3 periods beginning during fiscal year 1996 increased
 4 by the SNF market basket percentage increase (as
 5 defined in section 1888A(e)(3)) for fiscal year 1997;
 6 and

7 “(B) for cost reporting periods beginning dur-
 8 ing a subsequent fiscal year, the amount determined
 9 under this paragraph for the previous fiscal year in-
 10 creased by the SNF market basket percentage in-
 11 crease for such subsequent fiscal year.”.

12 (d) IMPOSITION OF LIMITS FOR ALL COST REPORT-
 13 ING PERIODS.—Section 1888(a) (42 U.S.C. 1395yy(a)) is
 14 amended in the matter preceding paragraph (1) by insert-
 15 ing after “extended care services” the following: “(for any
 16 cost reporting period for which payment is made under
 17 this title to the skilled nursing facility for such services)”.

18 **SEC. 15524. REDUCTIONS IN PAYMENT FOR CAPITAL-RE-**
 19 **LATED COSTS.**

20 Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)), as
 21 amended by section 15506, is amended by adding at the
 22 end the following new subparagraph:

23 “(U) Such regulations shall provide that, in deter-
 24 mining the amount of the payments that may be made
 25 under this title with respect to all the capital-related costs

1 of skilled nursing facilities, the Secretary shall reduce the
2 amounts of such payments otherwise established under
3 this title by 15 percent for payments attributable to por-
4 tions of cost reporting periods occurring during fiscal
5 years 1996 through 2002.”.

6 **SEC. 15525. TREATMENT OF ITEMS AND SERVICES PAID**
7 **FOR UNDER PART B.**

8 (a) **REQUIRING PAYMENT FOR ALL ITEMS AND**
9 **SERVICES TO BE MADE TO FACILITY.—**

10 (1) **IN GENERAL.—**The first sentence of section
11 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended—

12 (A) by striking “and (D)” and inserting
13 “(D)”; and

14 (B) by striking the period at the end and
15 inserting the following: “, and (E) in the case
16 of an item or service (other than physicians’
17 services and other than a portable X-ray or
18 portable electrocardiogram treated as a physi-
19 cian’s service for purposes of section
20 1848(j)(3)) furnished to an individual who (at
21 the time the item or service is furnished) is a
22 resident of a skilled nursing facility, payment
23 shall be made to the facility (without regard to
24 whether or not the item or service was fur-
25 nished by the facility, by others under arrange-

1 ment with them made by the facility, or other-
2 wise).”.

3 (2) EXCLUSION FOR ITEMS AND SERVICES NOT
4 BILLED BY FACILITY.—Section 1862(a) (42 U.S.C.
5 1395y(a)) is amended—

6 (A) by striking “or” at the end of para-
7 graph (14);

8 (B) by striking the period at the end of
9 paragraph (15) and inserting “; or”; and

10 (C) by inserting after paragraph (15) the
11 following new paragraph:

12 “(16) where such expenses are for covered non-
13 routine services (as defined in section 1888A(a)(1))
14 (other than a portable X-ray or portable electro-
15 cardiogram treated as a physician’s service for pur-
16 poses of section 1848(j)(3)) furnished to an individ-
17 ual who is a resident of a skilled nursing facility and
18 for which the claim for payment under this title is
19 not submitted by the facility.”.

20 (3) CONFORMING AMENDMENT.—Section
21 1832(a)(1) (42 U.S.C. 1395k(a)(1)) is amended by
22 striking “(2);” and inserting “(2) and section
23 1842(b)(6)(E);”.

24 (b) REDUCTION IN PAYMENTS FOR ITEMS AND SERV-
25 ICES FURNISHED BY OR UNDER ARRANGEMENTS WITH

1 FACILITIES.—Section 1861(v)(1) (42 U.S.C.
2 1395x(v)(1)), as amended by sections 15506 and 15524,
3 is amended by adding at the end the following new sub-
4 paragraph:

5 “(V) In the case of an item or service furnished by
6 a skilled nursing facility (or by others under arrangement
7 with them made by a skilled nursing facility) for which
8 payment is made under part B in an amount determined
9 in accordance with section 1833(a)(2)(B), the Secretary
10 shall reduce the reasonable cost for such item or service
11 otherwise determined under clause (i)(I) of such section
12 by 5.8 percent for payments attributable to portions of
13 cost reporting periods occurring during fiscal years 1996
14 through 2002.”.

15 **SEC. 15526. CERTIFICATION OF FACILITIES MEETING RE-**
16 **ISED NURSING HOME REFORM STANDARDS.**

17 (a) IN GENERAL.—Section 1819(a)(3) (42 U.S.C.
18 1395i–3(a)(3)) is amended to read as follows:

19 “(3)(A) is certified by the Secretary as meeting
20 the standards established under subsection (b), or
21 (B) is a State-certified facility (as defined in sub-
22 section (d)).”.

23 (b) REQUIREMENTS DESCRIBED.—Section 1819 (42
24 U.S.C. 1395i–3) is amended by striking subsections (b)
25 through (i) and inserting the following:

1 “(b) STANDARDS FOR AND CERTIFICATION OF FA-
2 CILITIES.—

3 “(1) STANDARDS FOR FACILITIES.—

4 “(A) IN GENERAL.—The Secretary shall
5 provide for the establishment and maintenance
6 of standards consistent with the contents de-
7 scribed in subparagraph (B) for skilled nursing
8 facilities which furnish services for which pay-
9 ment may be made under this title.

10 “(B) CONTENTS OF STANDARDS.—The
11 standards established for facilities under this
12 paragraph shall contain provisions relating to
13 the following items:

14 “(i) The treatment of resident medical
15 records.

16 “(ii) Policies, procedures, and bylaws
17 for operation.

18 “(iii) Quality assurance systems.

19 “(iv) Resident assessment procedures,
20 including care planning and outcome eval-
21 uation.

22 “(v) The assurance of a safe and ade-
23 quate physical plant for the facility.

24 “(vi) Qualifications for staff sufficient
25 to provide adequate care.

1 “(vii) Utilization review.

2 “(viii) The protection and enforce-
3 ment of resident rights described in sub-
4 paragraph (C).

5 “(C) RESIDENT RIGHTS DESCRIBED.—The
6 resident rights described in this subparagraph
7 are the rights of residents to the following:

8 “(i) To exercise the individual’s rights
9 as a resident of the facility and as a citizen
10 or resident of the United States.

11 “(ii) To receive notice of rights and
12 services.

13 “(iii) To be protected against the mis-
14 use of resident funds.

15 “(iv) To be provided privacy and con-
16 fidentiality.

17 “(v) To voice grievances.

18 “(vi) To examine the results of inspec-
19 tions under the certification program.

20 “(vii) To refuse to perform services
21 for the facility.

22 “(viii) To be provided privacy in com-
23 munications and to receive mail.

24 “(ix) To have the facility provide im-
25 mediate access to any resident by any rep-

1 representative of the certification program,
2 the resident's individual physician, the
3 State long term care ombudsman, and any
4 person the resident has designated as a
5 visitor.

6 “(x) To retain and use personal prop-
7 erty.

8 “(xi) To be free from abuse, including
9 verbal, sexual, physical and mental abuse,
10 corporal punishment, and involuntary se-
11 clusion.

12 “(xii) To be provided with prior writ-
13 ten notice of a pending transfer or dis-
14 charge.

15 “(D) REQUIRING NOTICE AND COM-
16 MENT.—The standards established for facilities
17 under this paragraph may only take effect after
18 the Secretary has provided the public with no-
19 tice and an opportunity for comment.

20 “(2) CERTIFICATION PROGRAM.—

21 “(A) IN GENERAL.—The Secretary shall
22 provide for the establishment and operation of
23 a program consistent with the requirements of
24 subparagraph (B) for the certification of skilled
25 nursing facilities which meet the standards es-

1 tablished under paragraph (1) and the decerti-
2 fication of facilities which fail to meet such
3 standards.

4 “(B) REQUIREMENTS FOR PROGRAM.—In
5 addition to any other requirements the Sec-
6 retary may impose, in establishing and operat-
7 ing the certification program under subpara-
8 graph (A), the Secretary shall ensure the fol-
9 lowing:

10 “(i) The Secretary shall ensure public
11 access (as defined by the Secretary) to the
12 certification program’s evaluations of par-
13 ticipating facilities, including compliance
14 records and enforcement actions and other
15 reports by the Secretary regarding the
16 ownership, compliance histories, and serv-
17 ices provided by certified facilities.

18 “(ii) Not less often than every 4
19 years, the Secretary shall audit its expendi-
20 tures under the program, through an en-
21 tity designated by the Secretary which is
22 not affiliated with the program, as des-
23 ignated by the Secretary.

24 “(c) INTERMEDIATE SANCTION AUTHORITY.—

1 “(1) **AUTHORITY.**—In addition to any other au-
 2 thority, where the Secretary determines that a nurs-
 3 ing facility which is certified for participation under
 4 this title (whether certified by the Secretary as
 5 meeting the standards established under subsection
 6 (b) or a State-certified facility) no longer or does
 7 not substantially meet the requirements for such a
 8 facility under this title as specified under subsection
 9 (b) and further determines that the facility’s defi-
 10 ciencies—

11 “(A) immediately jeopardize the health and
 12 safety of its residents, the Secretary shall at
 13 least provide for the termination of the facility’s
 14 certification for participation under this title, or

15 “(B) do not immediately jeopardize the
 16 health and safety of its residents, the Secretary
 17 may, in lieu of providing for terminating the fa-
 18 cility’s certification for participation under the
 19 plan, provide lesser sanctions including one that
 20 provides that no payment will be made under
 21 this title with respect to any individual admit-
 22 ted to such facility after a date specified by the
 23 Secretary.

24 “(2) **NOTICE.**—The Secretary shall not make
 25 such a decision with respect to a facility until the fa-

1 cility has had a reasonable opportunity, following the
2 initial determination that it no longer or does not
3 substantially meet the requirements for such a facil-
4 ity under this title, to correct its deficiencies, and,
5 following this period, has been given reasonable no-
6 tice and opportunity for a hearing.

7 “(3) EFFECTIVENESS.—The Secretary’s deci-
8 sion to deny payment may be made effective only
9 after such notice to the public and to the facility as
10 may be provided for by the Secretary, and its effec-
11 tiveness shall terminate (A) when the Secretary
12 finds that the facility is in substantial compliance
13 (or is making good faith efforts to achieve substan-
14 tial compliance) with the requirements for such a fa-
15 cility under this title, or (B) in the case described
16 in paragraph (1)(B), with the end of the eleventh
17 month following the month such decision is made ef-
18 fective, whichever occurs first. If a facility to which
19 clause (B) of the previous sentence applies still fails
20 to substantially meet the provisions of the respective
21 section on the date specified in such clause, the Sec-
22 retary shall terminate such facility’s certification for
23 participation under this title effective with the first
24 day of the first month following the month specified
25 in such clause.

1 “(d) STATE-CERTIFIED FACILITY DEFINED.—In
2 subsection (a), a ‘State-certified facility’ means a facility
3 licensed or certified as a skilled nursing facility by the
4 State in which it is located, or a facility which otherwise
5 meets the requirements applicable to providers of nursing
6 facility services under the State plan under title XIX or
7 the MediGrant program under title XXI.”.

8 (c) CONFORMING AMENDMENTS.—(1) Section
9 1861(v)(1)(E) (42 U.S.C. 1395x(v)(1)(E)) is amended by
10 striking the second sentence.

11 (2) Section 1864 (42 U.S.C. 1395aa) is amended by
12 striking subsection (d).

13 (3) Section 1866(f)(1) (42 U.S.C. 1395cc(f)(1)) is
14 amended by striking “1819(c)(2)(E),”.

15 (4) Section 1883(f) (42 U.S.C. 1395tt(f)) is amend-
16 ed—

17 (A) in the second sentence, by striking “such a
18 hospital” and inserting “a hospital which enters into
19 an agreement with the Secretary under this section”;
20 and

21 (B) by striking the first sentence.

22 (d) EFFECTIVE DATE.—The amendments made by
23 this section shall apply with respect to cost reporting peri-
24 ods beginning on or after October 1, 1995.

1 **SEC. 15527. MEDICAL REVIEW PROCESS.**

2 In order to ensure that medicare beneficiaries are
3 furnished appropriate extended care services, the Sec-
4 retary of Health and Human Services shall establish and
5 implement a thorough medical review process to examine
6 the effects of the amendments made by this part on the
7 quality of extended care services furnished to medicare
8 beneficiaries. In developing such a medical review process,
9 the Secretary shall place a particular emphasis on the
10 quality of non-routine covered services for which payment
11 is made under section 1888A of the Social Security Act.

12 **SEC. 15528. REPORT BY MEDICARE PAYMENT REVIEW COM-**
13 **MISSION.**

14 Not later than October 1, 1997, the Medicare Pay-
15 ment Review Commission shall submit to Congress a re-
16 port on the system under which payment is made under
17 the medicare program for extended care services furnished
18 by skilled nursing facilities, and shall include in the report
19 the following:

20 (1) An analysis of the effect of the methodology
21 established under section 1888A of the Social Secu-
22 rity Act (as added by section 15522) on the pay-
23 ments for, and the quality of, extended care services
24 under the medicare program.

25 (2) An analysis of the advisability of determin-
26 ing the amount of payment for covered non-routine

1 services of facilities (as described in such section) on
 2 the basis of the amounts paid for such services when
 3 furnished by suppliers under part B of the medicare
 4 program.

5 (3) An analysis of the desirability of maintain-
 6 ing separate limits for hospital-based and freestand-
 7 ing facilities in the costs of extended care services
 8 recognized as reasonable under the medicare pro-
 9 gram.

10 (4) An analysis of the quality of services fur-
 11 nished by skilled nursing facilities.

12 (5) An analysis of the adequacy of the process
 13 and standards used to provide exceptions to the lim-
 14 its described in paragraph (3).

15 **SEC. 15529. EFFECTIVE DATE.**

16 Except as otherwise provided in this part, the amend-
 17 ments made by this part shall apply to services furnished
 18 during cost reporting periods (or portions of cost reporting
 19 periods) beginning on or after October 1, 1996.

1 PART 3—CLARIFICATION OF CREDITS TO PART A

2 TRUST FUND

**SEC. 15531. CLARIFICATION OF AMOUNT OF TAXES CRED-
ITED TO FEDERAL HOSPITAL INSURANCE
TRUST FUND.**

Section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21) is amended by adding at the end the following: “The Secretary of the Treasury shall carry out this subparagraph without regard to any amendments to this subsection or to section 86 of the Internal Revenue Code of 1986 which take effect on or after January 1, 1994.”.

**3 Subtitle G—Provisions Relating to
4 Medicare Part B**

5 PART 1—PAYMENT REFORMS

6 SEC. 15601. PAYMENTS FOR PHYSICIANS’ SERVICES.

7 (a) REPLACEMENT OF VOLUME PERFORMANCE
8 STANDARD WITH SUSTAINABLE GROWTH RATE.—Section
9 1848(f) (42 U.S.C. 1395w–4(f)) is amended to read as
10 follows:

11 “(f) SUSTAINABLE GROWTH RATE.—

12 “(1) SPECIFICATION OF GROWTH RATE.—

13 “(A) FISCAL YEAR 1996.—The sustainable
14 growth rate for all physicians’ services for fiscal
15 year 1996 shall be equal to the product of—

1 “(i) 1 plus the Secretary’s estimate of
 2 the percentage change in the medicare eco-
 3 nomic index for 1996 (described in the
 4 fourth sentence of section 1842(b)(3)) (di-
 5 vided by 100),

6 “(ii) 1 plus the Secretary’s estimate of
 7 the percentage change (divided by 100) in
 8 the average number of individuals enrolled
 9 under this part (other than private plan
 10 enrollees) from fiscal year 1995 to fiscal
 11 year 1996,

12 “(iii) 1 plus the Secretary’s estimate
 13 of the projected percentage growth in real
 14 gross domestic product per capita (divided
 15 by 100) from fiscal year 1995 to fiscal
 16 year 1996, plus 2 percentage points, and

17 “(iv) 1 plus the Secretary’s estimate
 18 of the percentage change (divided by 100)
 19 in expenditures for all physicians’ services
 20 in fiscal year 1996 (compared with fiscal
 21 year 1995) which will result from changes
 22 in law, determined without taking into ac-
 23 count estimated changes in expenditures
 24 due to changes in the volume and intensity
 25 of physicians’ services or changes in ex-

1 penditures resulting from changes in the
2 update to the conversion factor under sub-
3 section (d),

4 minus 1 and multiplied by 100.

5 “(B) SUBSEQUENT FISCAL YEARS.—The
6 sustainable growth rate for all physicians’ serv-
7 ices for fiscal year 1997 and each subsequent
8 fiscal year shall be equal to the product of—

9 “(i) 1 plus the Secretary’s estimate of
10 the percentage change in the medicare eco-
11 nomic index for the fiscal year involved
12 (described in the fourth sentence of section
13 1842(b)(3)) (divided by 100),

14 “(ii) 1 plus the Secretary’s estimate of
15 the percentage change (divided by 100) in
16 the average number of individuals enrolled
17 under this part (other than private plan
18 enrollees) from the previous fiscal year to
19 the fiscal year involved,

20 “(iii) 1 plus the Secretary’s estimate
21 of the projected percentage growth in real
22 gross domestic product per capita (divided
23 by 100) from the previous fiscal year to
24 the fiscal year involved, plus 2 percentage
25 points, and

1 “(iv) 1 plus the Secretary’s estimate
 2 of the percentage change (divided by 100)
 3 in expenditures for all physicians’ services
 4 in the fiscal year (compared with the pre-
 5 vious fiscal year) which will result from
 6 changes in law (including changes made by
 7 the Secretary in response to section 1895),
 8 determined without taking into account es-
 9 timated changes in expenditures due to
 10 changes in the volume and intensity of
 11 physicians’ services or changes in expendi-
 12 tures resulting from changes in the update
 13 to the conversion factor under subsection
 14 (d)(3),

15 minus 1 and multiplied by 100.

16 “(2) EXCLUSION OF SERVICES FURNISHED TO
 17 PRIVATE PLAN ENROLLEES.—In this subsection, the
 18 term ‘physicians’ services’ with respect to a fiscal
 19 year does not include services furnished to an indi-
 20 vidual enrolled under this part who has elected to re-
 21 ceive benefits under this title for the fiscal year
 22 through a MedicarePlus product offered under part
 23 C or through enrollment with an eligible organiza-
 24 tion with a risk-sharing contract under section
 25 1876.”.

1 (b) ESTABLISHING UPDATE TO CONVERSION FAC-
2 TOR TO MATCH SPENDING UNDER SUSTAINABLE
3 GROWTH RATE.—

4 (1) IN GENERAL.—Section 1848(d) (42 U.S.C.
5 1395w-4(d)) is amended—

6 (A) by striking paragraph (2);

7 (B) by amending paragraph (3) to read as
8 follows:

9 “(3) UPDATE.—

10 “(A) IN GENERAL.—Subject to subpara-
11 graph (E), for purposes of this section the up-
12 date for a year (beginning with 1997) is equal
13 to the product of—

14 “(i) 1 plus the Secretary’s estimate of
15 the percentage increase in the medicare
16 economic index (described in the fourth
17 sentence of section 1842(b)(3)) for the
18 year (divided by 100), and

19 “(ii) 1 plus the Secretary’s estimate of
20 the update adjustment factor for the year
21 (divided by 100),

22 minus 1 and multiplied by 100.

23 “(B) UPDATE ADJUSTMENT FACTOR.—The
24 ‘update adjustment factor’ for a year is equal to
25 the quotient of—

1 “(i) the difference between (I) the
 2 sum of the allowed expenditures for physi-
 3 cians’ services furnished during each of the
 4 years 1995 through the year involved and
 5 (II) the sum of the amount of actual ex-
 6 penditures for physicians’ services fur-
 7 nished during each of the years 1995
 8 through the previous year; divided by

9 “(ii) the Secretary’s estimate of al-
 10 lowed expenditures for physicians’ services
 11 furnished during the year.

12 “(C) DETERMINATION OF ALLOWED EX-
 13 PENDITURES.—For purposes of subparagraph
 14 (B), allowed expenditures for physicians’ serv-
 15 ices shall be determined as follows (as esti-
 16 mated by the Secretary):

17 “(i) In the case of allowed expendi-
 18 tures for 1995, such expenditures shall be
 19 equal to actual expenditures for services
 20 furnished during the 12-month period end-
 21 ing with June of 1995.

22 “(ii) In the case of allowed expendi-
 23 tures for 1996 and each subsequent year,
 24 such expenditures shall be equal to allowed
 25 expenditures for the previous year, in-

1 creased by the sustainable growth rate
2 under subsection (f) for the fiscal year
3 which begins during the year.

4 “(D) DETERMINATION OF ACTUAL EX-
5 PENDITURES.—For purposes of subparagraph
6 (B), the amount of actual expenditures for phy-
7 sicians’ services furnished during a year shall
8 be equal to the amount of expenditures for such
9 services during the 12-month period ending
10 with June of the previous year.

11 “(E) RESTRICTION ON VARIATION FROM
12 MEDICARE ECONOMIC INDEX.—

13 “(i) IN GENERAL.—Notwithstanding
14 the amount of the update adjustment fac-
15 tor determined under subparagraph (B)
16 for a year, the update in the conversion
17 factor under this paragraph for the year
18 may not be—

19 “(I) greater than 103 percent of
20 1 plus the Secretary’s estimate of the
21 percentage increase in the medicare
22 economic index (described in the
23 fourth sentence of section 1842(b)(3))
24 for the year (divided by 100); or

1 “(II) less than the applicable per-
 2 centage limit of 1 plus the Secretary’s
 3 estimate of the percentage increase in
 4 the medicare economic index (de-
 5 scribed in the fourth sentence of sec-
 6 tion 1842(b)(3)) for the year (divided
 7 by 100).

8 “(ii) APPLICABLE PERCENTAGE
 9 LIMIT.—In clause (i)(II), the ‘applicable
 10 percentage limit’ for a year is—

11 “(I) for 1997, 93 percent;

12 “(II) for 1998, 92.25 percent;

13 and

14 “(III) for 1999 and each suc-
 15 ceeding year, 92 percent.”; and

16 (C) by adding at the end the following new
 17 paragraph:

18 “(4) REPORTING REQUIREMENTS.—

19 “(A) IN GENERAL.—Not later than No-
 20 vember 1 of each year (beginning with 1996),
 21 the Secretary shall transmit to the Congress a
 22 report that describes the update in the conver-
 23 sion factor for physicians’ services (as defined
 24 in subsection (f)(3)(A)) in the following year.

1 “(B) COMMISSION REVIEW.—The Medicare
2 Payment Review Commission shall review the
3 report submitted under subparagraph (A) for a
4 year and shall submit to the Congress, by not
5 later than December 1 of the year, a report
6 containing its analysis of the conversion factor
7 for the following year.”.

8 (2) EFFECTIVE DATE.—The amendments made
9 by this subsection shall apply to physicians’ services
10 furnished on or after January 1, 1996.

11 (c) ESTABLISHMENT OF SINGLE CONVERSION FAC-
12 TOR FOR 1996.—

13 (1) IN GENERAL.—Section 1848(d)(1) (42
14 U.S.C. 1395w-4(d)(1)) is amended—

15 (A) by redesignating subparagraph (C) as
16 subparagraph (D); and

17 (B) by inserting after subparagraph (B)
18 the following new subparagraph:

19 “(C) SPECIAL RULE FOR 1996.—For
20 1996, the conversion factor under this sub-
21 section shall be \$35.42 for all physicians’ serv-
22 ices.”.

23 (2) CONFORMING AMENDMENTS.—Section 1848
24 (42 U.S.C. 1395w-4), as amended by paragraph (1),
25 is amended—

1 (A) by striking “(or factors)” each place it
 2 appears in subsection (d)(1)(A) and
 3 (d)(1)(D)(ii);

4 (B) in subsection (d)(1)(A), by striking “or
 5 updates”;

6 (C) in subsection (d)(1)(D)(ii), by striking
 7 “(or updates)” and

8 (D) in subsection (i)(1)(C), by striking
 9 “conversion factors” and inserting “the conver-
 10 sion factor”.

11 **SEC. 15602. ELIMINATION OF FORMULA-DRIVEN OVERPAY-**
 12 **MENTS FOR CERTAIN OUTPATIENT HOSPITAL**
 13 **SERVICES.**

14 (a) AMBULATORY SURGICAL CENTER PROCE-
 15 DURES.—Section 1833(i)(3)(B)(i)(II) (42 U.S.C.
 16 1395l(i)(3)(B)(i)(II)) is amended—

17 (1) by striking “of 80 percent”; and

18 (2) by striking the period at the end and insert-
 19 ing the following: “, less the amount a provider may
 20 charge as described in clause (ii) of section
 21 1866(a)(2)(A).”.

22 (b) RADIOLOGY SERVICES AND DIAGNOSTIC PROCE-
 23 DURES.—Section 1833(n)(1)(B)(i)(II) (42 U.S.C.
 24 1395l(n)(1)(B)(i)(II)) is amended—

25 (1) by striking “of 80 percent”; and

1 (2) by striking the period at the end and insert-
 2 ing the following: “, less the amount a provider may
 3 charge as described in clause (ii) of section
 4 1866(a)(2)(A).”.

5 (c) EFFECTIVE DATE.—The amendments made by
 6 this section shall apply to services furnished during por-
 7 tions of cost reporting periods occurring on or after Octo-
 8 ber 1, 1995.

9 **SEC. 15603. PAYMENTS FOR DURABLE MEDICAL EQUIP-**
 10 **MENT.**

11 (a) REDUCTION IN PAYMENT AMOUNTS FOR ITEMS
 12 OF DURABLE MEDICAL EQUIPMENT.—

13 (1) FREEZE IN UPDATE FOR COVERED
 14 ITEMS.—Section 1834(a)(14) (42 U.S.C.
 15 1395m(a)(14)) is amended—

16 (A) by striking “and” at the end of sub-
 17 paragraph (A);

18 (B) in subparagraph (B)—

19 (i) by striking “a subsequent year”
 20 and inserting “1993, 1994, and 1995”,
 21 and

22 (ii) by striking the period at the end
 23 and inserting a semicolon; and

24 (C) by adding at the end the following:

1 “(C) for each of the years 1996 through
2 2002, 0 percentage points; and

3 “(D) for a subsequent year, the percentage
4 increase in the consumer price index for all
5 urban consumers (U.S. urban average) for the
6 12-month period ending with June of the pre-
7 vious year.”.

8 (2) UPDATE FOR ORTHOTICS AND PROSTHET-
9 ICS.—Section 1834(h)(4)(A) (42 U.S.C.
10 1395m(h)(4)(A)) is amended—

11 (A) by striking “and” at the end of clause
12 (iii);

13 (B) by redesignating clause (iv) as clause
14 (v); and

15 (C) by inserting after clause (iii) the fol-
16 lowing new clause:

17 “(iv) for each of the years 1996
18 through 2002, 1 percent, and”.

19 (b) OXYGEN AND OXYGEN EQUIPMENT.—Section
20 1834(a)(9)(C) (42 U.S.C. 1395m(a)(9)(C)) is amended—

21 (1) by striking “and” at the end of clause (iii);

22 (2) in clause (iv)—

23 (A) by striking “a subsequent year” and
24 inserting “1993, 1994, and 1995”, and

1 (B) by striking the period at the end and
2 inserting a semicolon; and

3 (3) by adding at the end the following new
4 clauses:

5 “(v) in 1996, is 80 percent of the na-
6 tional limited monthly payment rate com-
7 puted under subparagraph (B) for the item
8 for the year; and

9 “(vi) in a subsequent year, is the na-
10 tional limited monthly payment rate com-
11 puted under subparagraph (B) for the item
12 for the year.”.

13 (c) PAYMENT FOR UPGRADED DURABLE MEDICAL
14 EQUIPMENT.—Section 1834(a) (42 U.S.C. 1395m(a)) is
15 amended by inserting after paragraph (15) the following
16 new paragraph:

17 “(16) PAYMENT FOR CERTAIN UPGRADED
18 ITEMS.—

19 “(A) INDIVIDUAL’S RIGHT TO CHOOSE UP-
20 GRADED ITEM.—Notwithstanding any other
21 provision of this title, effective on the date on
22 which the Secretary issues regulations under
23 subparagraph (C), payment may be made under
24 this part for an upgraded item of durable medi-
25 cal equipment in the same manner as payment

1 may be made for a standard item of durable
2 medical equipment.

3 “(B) PAYMENTS TO SUPPLIER.—In the
4 case of the purchase or rental of an upgraded
5 item under subparagraph (A)—

6 “(i) the supplier shall receive payment
7 under this subsection with respect to such
8 item as if such item were a standard item;
9 and

10 “(ii) the individual purchasing or
11 renting the item shall pay the supplier an
12 amount equal to the difference between the
13 supplier’s charge and the amount under
14 clause (i).

15 In no event may the supplier’s charge for an
16 upgraded item exceed the applicable fee sched-
17 ule amount (if any) for such item.

18 “(C) CONSUMER PROTECTION SAFE-
19 GUARDS.—The Secretary shall issue regulations
20 providing for consumer protection standards
21 with respect to the furnishing of upgraded
22 equipment under subparagraph (A). Such regu-
23 lations shall provide for—

24 “(i) full disclosure by the supplier of
25 the availability and price of standard items

1 and proof of receipt of such disclosure in-
 2 formation by the beneficiary before the fur-
 3 nishing of the upgraded item;

4 “(ii) conditions of participation for
 5 suppliers of upgraded items, including con-
 6 ditions relating to billing procedures;

7 “(iii) sanctions (including exclusion)
 8 of suppliers who are determined to have
 9 engaged in coercive or abusive practices;
 10 and

11 “(iv) such other safeguards as the
 12 Secretary determines are necessary.”.

13 (d) PAYMENT FREEZE FOR PARENTERAL AND EN-
 14 TERAL NUTRIENTS, SUPPLIES, AND EQUIPMENT.—In de-
 15 termining the amount of payment under part B of title
 16 XVIII of the Social Security Act with respect to parenteral
 17 and enteral nutrients, supplies, and equipment during
 18 each of the years 1996 through 2002, the charges deter-
 19 mined to be reasonable with respect to such nutrients,
 20 supplies, and equipment may not exceed the charges deter-
 21 mined to be reasonable with respect to such nutrients,
 22 supplies, and equipment during 1993.

1 **SEC. 15604. REDUCTION IN UPDATES TO PAYMENT**
 2 **AMOUNTS FOR CLINICAL DIAGNOSTIC LAB-**
 3 **ORATORY TESTS.**

4 (a) CHANGE IN UPDATE.—Section
 5 1833(h)(2)(A)(ii)(IV) (42 U.S.C. 1395l(h)(2)(A)(ii)(IV))
 6 is amended by striking “1994 and 1995” and inserting
 7 “1994 through 2002”.

8 (b) LOWERING CAP ON PAYMENT AMOUNTS.—Sec-
 9 tion 1833(h)(4)(B) (42 U.S.C. 1395l(h)(4)(B)) is amend-
 10 ed—

11 (1) in clause (vi), by striking “and” at the end;

12 (2) in clause (vii)—

13 (A) by inserting “and before January 1,
 14 1997,” after “1995,” and

15 (B) by striking the period at the end and
 16 inserting “, and”; and

17 (3) by adding at the end the following new
 18 clause:

19 “(viii) after December 31, 1996, is equal to 65
 20 percent of such median.”.

21 **SEC. 15605. EXTENSION OF REDUCTIONS IN PAYMENTS FOR**
 22 **COSTS OF HOSPITAL OUTPATIENT SERVICES.**

23 (a) REDUCTION IN PAYMENTS FOR CAPITAL-RELAT-
 24 ED COSTS.—Section 1861(v)(1)(S)(ii)(I) (42 U.S.C.
 25 1395x(v)(1)(S)(ii)(I)) is amended by striking “through
 26 1998” and inserting “through 2002”.

1 (b) REDUCTION IN PAYMENTS FOR OTHER COSTS.—
 2 Section 1861(v)(1)(S)(ii)(II) (42 U.S.C.
 3 1395x(v)(1)(S)(ii)(II)) is amended by striking “through
 4 1998” and inserting “through 2002”.

5 **SEC. 15606. FREEZE IN PAYMENTS FOR AMBULATORY SUR-**
 6 **GICAL CENTER SERVICES.**

7 The Secretary of Health and Human Services shall
 8 not provide for any inflation update in the payment
 9 amounts under subparagraphs (A) and (B) of section
 10 1833(i)(2) of the Social Security Act for any of the fiscal
 11 years 1996 through 2002.

12 **SEC. 15607. RURAL EMERGENCY ACCESS CARE HOSPITALS.**

13 (a) COVERAGE UNDER PART B.—Section 1832(a)(2)
 14 (42 U.S.C. 1395k(a)(2)) is amended—

15 (1) by striking “and” at the end of subpara-
 16 graph (I);

17 (2) by striking the period at the end of sub-
 18 paragraph (J) and inserting “; and”; and

19 (3) by adding at the end the following new sub-
 20 paragraph:

21 “(K) rural emergency access care hospital
 22 services (as defined in section 1861(oo)(2)).”.

23 (b) PAYMENT BASED ON PAYMENT FOR OUTPATIENT
 24 RURAL PRIMARY CARE HOSPITAL SERVICES.—

1 (1) IN GENERAL.—Section 1833(a)(6) (42
2 U.S.C. 1395l(a)(6)) is amended by striking “serv-
3 ices,” and inserting “services and rural emergency
4 access care hospital services,”.

5 (2) PAYMENT METHODOLOGY DESCRIBED.—
6 Section 1834(g) (42 U.S.C. 1395m(g)) is amend-
7 ed—

8 (A) in the heading, by striking “SERV-
9 ICES” and inserting “SERVICES AND RURAL
10 EMERGENCY ACCESS CARE HOSPITAL SERV-
11 ICES”; and

12 (B) by adding at the end the following new
13 sentence: “The amount of payment for rural
14 emergency access care hospital services provided
15 during a year shall be determined using the ap-
16 plicable method provided under this subsection
17 for determining payment for outpatient rural
18 primary care hospital services during the
19 year.”.

20 (c) EFFECTIVE DATE.—The amendments made by
21 this section shall apply to services furnished on or after
22 October 1, 1995.

1 **SEC. 15608. ENSURING PAYMENT FOR PHYSICIAN AND**
 2 **NURSE FOR JOINTLY FURNISHED ANESTHE-**
 3 **SIA SERVICES.**

4 (a) PAYMENT FOR JOINTLY FURNISHED SINGLE
 5 CASE.—

6 (1) PAYMENT TO PHYSICIAN.—Section
 7 1848(a)(4) (42 U.S.C. 1395w-4(a)(4)) is amended
 8 by adding at the end the following new subpara-
 9 graph:

10 “(C) PAYMENT FOR SINGLE CASE.—Not-
 11 withstanding section 1862(a)(1)(A), with re-
 12 spect to physicians’ services consisting of the
 13 furnishing of anesthesia services for a single
 14 case that are furnished jointly with a certified
 15 registered nurse anesthetist, if the carrier de-
 16 termines that the use of both the physician and
 17 the nurse anesthetist to furnish the anesthesia
 18 service was not medically necessary, the fee
 19 schedule amount for the physicians’ services
 20 shall be equal to 50 percent (or 55 percent, in
 21 the case of services furnished during 1996 or
 22 1997) of the fee schedule amount applicable
 23 under this section for anesthesia services per-
 24 sonally performed by the physician alone (with-
 25 out regard to this subparagraph). Nothing in
 26 this subparagraph may be construed to affect

1 the application of any provision of law regard-
2 ing balance billing.”.

3 (2) PAYMENT TO CRNA.—Section 1833(l)(4)(B)
4 (42 U.S.C. 1395l(l)(4)(B)) is amended by adding at
5 the end the following new clause:

6 “(iv) Notwithstanding section 1862(a)(1)(A), in the
7 case of services of a certified registered nurse anesthetist
8 consisting of the furnishing of anesthesia services for a
9 single case that are furnished jointly with a physician, if
10 the carrier determines that the use of both the physician
11 and the nurse anesthetist to furnish the anesthesia service
12 was not medically necessary, the fee schedule amount for
13 the services furnished by the certified registered nurse an-
14 esthetist shall be equal to 50 percent (or 40 percent, in
15 the case of services furnished during 1996 or 1997) of
16 the fee schedule amount applicable under section 1848 for
17 anesthesia services personally performed by the physician
18 alone (without regard to this clause).”.

19 (b) EFFECTIVE DATE.—The amendments made by
20 subsections (a) shall apply to services furnished on or after
21 July 1, 1996.

22 **SEC. 15609. STATEWIDE FEE SCHEDULE AREA FOR PHYSI-**
23 **CIANS’ SERVICES.**

24 (a) IN GENERAL.—Notwithstanding section
25 1848(j)(2) of the Social Security Act, in the case of the

1 State of Wisconsin, the Secretary of Health and Human
2 Services shall treat the State as a single fee schedule area
3 for purposes of determining the fee schedule amount (as
4 referred to in section 1848(a) of such Act) for physicians'
5 services (as defined in section 1848(j)(3) of such Act)
6 under part B of the medicare program.

7 (b) BUDGET-NEUTRALITY.—Notwithstanding any
8 provision of part B of title XVIII of the Social Security
9 Act, the Secretary shall carry out subsection (a) in a man-
10 ner that ensures that total payments for physicians' serv-
11 ices (as so defined) furnished by physicians in Wisconsin
12 during a year are not greater or less than total payments
13 for such services would have been but for this section.

14 (c) CONSTRUCTION.—Nothing in this section shall be
15 construed as limiting the availability (to the Secretary, the
16 appropriate agency or organization with a contract under
17 section 1842 of such Act, or physicians in the State of
18 Wisconsin) of otherwise applicable administrative proce-
19 dures for modifying the fee schedule area or areas in the
20 State after implementation of subsection (a).

21 (d) EFFECTIVE DATE.—This section shall apply with
22 respect to physicians' services furnished on or after Janu-
23 ary 1, 1997.

1 **SEC. 15609A. ESTABLISHMENT OF FEE SCHEDULE FOR AM-**
 2 **BULANCE SERVICES.**

3 (a) PAYMENT IN ACCORDANCE WITH FEE SCHED-
 4 ULE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is
 5 amended—

6 (1) by striking “and (P)” and inserting “(P)”;
 7 and

8 (2) by striking the semicolon at the end and in-
 9 serting the following: “, and (Q) with respect to am-
 10 bulance service, the amounts paid shall be 80 per-
 11 cent of the lesser of the actual charge for the serv-
 12 ices or the amount determined by a fee schedule es-
 13 tablished by the Secretary for the purposes of this
 14 subparagraph (in accordance with section 15608(b)
 15 of the Medicare Preservation Act);”.

16 (b) REQUIREMENTS FOR ESTABLISHMENT OF FEE
 17 SCHEDULE.—

18 (1) IN GENERAL.—The Secretary of Health and
 19 Human Services shall establish the fee schedule for
 20 ambulance services under section 1833(a)(1)(Q) of
 21 the Social Security Act (as added by subsection (a))
 22 through a negotiated rulemaking process described
 23 in title 5, United States Code, and in accordance
 24 with the requirements of this subsection.

1 (2) CONSIDERATIONS.—In establishing the fee
2 schedule for ambulance services, the Secretary
3 shall—

4 (A) establish mechanisms to control in-
5 creases in expenditures for ambulance services
6 under part B of the medicare program which
7 fairly reflect the changing nature of the ambu-
8 lance service industry;

9 (B) establish definitions for ambulance
10 services which promote efficiency and link pay-
11 ments (including fees for assessment and treat-
12 ment services) to the type of service provided;

13 (C) take into account regional differences
14 which affect cost and productivity, including
15 differences in the costs of resources and the
16 costs of uncompensated care;

17 (D) apply dynamic adjustments to pay-
18 ment rates to account for inflation, demo-
19 graphic changes in the population of medicare
20 beneficiaries, and changes in the number of
21 providers of ambulance services participating in
22 the medicare program; and

23 (E) phase in the application of the pay-
24 ment rates under the fee schedule in an effi-
25 cient and fair manner.

1 (3) SAVINGS.—In establishing the fee schedule
2 for ambulance services, the Secretary shall—

3 (A) ensure that the aggregate amount of
4 payments made for ambulance services under
5 part B of the medicare program during 1998
6 does not exceed the aggregate amount of pay-
7 ments which would have been made for such
8 services under part B of the program during
9 1998 if the amendments made by this section
10 were not in effect; and

11 (B) set the payment amounts provided
12 under the fee schedule for services furnished in
13 1999 and each subsequent year at amounts
14 equal to the payment amounts under the fee
15 schedule for service furnished during the pre-
16 vious year, increased by the percentage increase
17 in the consumer price index for all urban con-
18 sumers (U.S. city average) for the 12-month
19 period ending with June of the previous year.

20 (4) CONSULTATION.—In establishing the fee
21 schedule for ambulance services, the Secretary shall
22 consult regularly with the American Ambulance As-
23 sociation, the National Association of State Medical
24 Directors, and other national organizations rep-
25 resenting individuals and entities who furnish or reg-

1 ulate ambulance services, and shall share with such
2 associations and organizations the data and data
3 analysis used in establishing the fee schedule, includ-
4 ing data on variations in payments for ambulance
5 services under part B of the medicare program for
6 years prior to 1998 among geographic areas and
7 types of ambulance service providers.

8 (c) EFFECTIVE DATE.—The amendment made by
9 subsection (a) and the fee schedule described in subsection
10 (b) shall apply to ambulance services furnished on or after
11 January 1, 1998.

12 **SEC. 15609B. STANDARDS FOR PHYSICAL THERAPY SERV-**
13 **ICES FURNISHED BY PHYSICIANS.**

(a) APPLICATION OF STANDARDS FOR OTHER PROVIDERS OF PHYSICAL THERAPY SERVICES TO SERVICES FURNISHED BY PHYSICIANS.—Section 1862(a) (42 U.S.C. 1395y(a)), as amended by section 15525(a)(2), is amended

19 (1) by striking “or” at the end of paragraph
20 (15);

(2) by striking the period at the end of paragraph (16) and inserting “; or”; and

(3) by inserting after paragraph (16) the following new paragraph:

1 “(17) in the case of physicians’ services under
2 section 1848(j)(3) consisting of outpatient physical
3 therapy services or outpatient occupational therapy
4 services, which are furnished by a physician who
5 does not meet the requirements applicable under sec-
6 tion 1861(p) to a clinic or rehabilitation agency fur-
7 nishing such services.”.

8 (b) CONFORMING AMENDMENT.—Section 1848(j)(3)
9 (42 U.S.C. 1395w–4(j)(3)) is amended by inserting “(sub-
10 ject to section 1862(a)(17))” after “(2)(D)”.

11 (c) EFFECTIVE DATE.—The amendments made by
12 this section shall apply to services furnished on or after
13 January 1, 1996.

14 **PART 2—PART B PREMIUM**

15 **SEC. 15611. EXTENSION OF PART B PREMIUM.**

16 (a) IN GENERAL.—Section 1839(e)(1) (42 U.S.C.
17 1395r(e)(1)) is amended—

18 (1) in subparagraph (A)—

19 (A) by striking “and prior to January
20 1999”, and

21 (B) by inserting “(or, if higher, the per-
22 cent described in subparagraph (C))” after “50
23 percent”; and

24 (2) by adding at the end the following new sub-
25 paragraph:

1 “(C) For purposes of subparagraph (A), the percent
2 described in this subparagraph is the ratio (expressed as
3 a percentage) of the monthly premium established under
4 this section for months in 1995 to the monthly actuarial
5 rate for enrollees age 65 and over applicable to such
6 months (as specified in the most recent report of the
7 Board of Trustees of the Federal Supplementary Medical
8 Insurance Trust Fund published prior to the date of the
9 enactment of the Medicare Preservation Act of 1995).”.

10 (b) EFFECTIVE DATE.—The amendments made by
11 subsection (a) apply to premiums for months beginning
12 with January 1996.

13 **SEC. 15612. INCOME-RELATED REDUCTION IN MEDICARE**
14 **SUBSIDY.**

15 (a) IN GENERAL.—Section 1839 (42 U.S.C. 1395r)
16 is amended by adding at the end the following:

17 “(h)(1) Notwithstanding the previous subsections of
18 this section, in the case of an individual whose modified
19 adjusted gross income for a taxable year ending with or
20 within a calendar year (as initially determined by the Sec-
21 retary in accordance with paragraph (3)) exceeds the
22 threshold amount described in paragraph (5)(B), the Sec-
23 retary shall increase the amount of the monthly premium
24 for months in the calendar year by an amount equal to
25 the difference between—

1 “(A) 200 percent of the monthly actuarial rate
2 for enrollees age 65 and over as determined under
3 subsection (a)(1) for that calendar year; and

4 “(B) the total of the monthly premiums paid by
5 the individual under this section (determined without
6 regard to subsection (b)) during such calendar year.

7 “(2) In the case of an individual described in para-
8 graph (1) whose modified adjusted gross income exceeds
9 the threshold amount by less than \$25,000, the amount
10 of the increase in the monthly premium applicable under
11 paragraph (1) shall be an amount which bears the same
12 ratio to the amount of the increase described in paragraph
13 (1) (determined without regard to this paragraph) as such
14 excess bears to \$25,000. In the case of a joint return filed
15 under section 6013 of the Internal Revenue Code of 1986
16 by spouses both of whom are enrolled under this part, the
17 previous sentence shall be applied by substituting
18 ‘\$50,000’ for ‘\$25,000’. The preceding provisions of this
19 paragraph shall not apply to any individual whose thresh-
20 old amount is zero.

21 “(3) The Secretary shall make an initial determina-
22 tion of the amount of an individual’s modified adjusted
23 gross income for a taxable year ending with or within a
24 calendar year for purposes of this subsection as follows:

1 “(A) Not later than October 1 of the year pre-
 2 ceding the year, the Secretary shall provide notice to
 3 each individual whom the Secretary finds (on the
 4 basis of the individual’s actual modified adjusted
 5 gross income for the most recent taxable year for
 6 which such information is available or other informa-
 7 tion provided to the Secretary by the Secretary of
 8 the Treasury) will be subject to an increase under
 9 this subsection that the individual will be subject to
 10 such an increase, and shall include in such notice
 11 the Secretary’s estimate of the individual’s modified
 12 adjusted gross income for the year.

13 “(B) If, during the 30-day period beginning on
 14 the date notice is provided to an individual under
 15 subparagraph (A), the individual provides the Sec-
 16 retary with information on the individual’s antici-
 17 pated modified adjusted gross income for the year,
 18 the amount initially determined by the Secretary
 19 under this paragraph with respect to the individual
 20 shall be based on the information provided by the
 21 individual.

22 “(C) If an individual does not provide the Sec-
 23 retary with information under subparagraph (B), the
 24 amount initially determined by the Secretary under
 25 this paragraph with respect to the individual shall be

1 the amount included in the notice provided to the in-
2 dividual under subparagraph (A).

3 “(4)(A) If the Secretary determines (on the basis of
4 final information provided by the Secretary of the Treas-
5 ury) that the amount of an individual’s actual modified
6 adjusted gross income for a taxable year ending with or
7 within a calendar year is less than or greater than the
8 amount initially determined by the Secretary under para-
9 graph (3), the Secretary shall increase or decrease the
10 amount of the individual’s monthly premium under this
11 section (as the case may be) for months during the follow-
12 ing calendar year by an amount equal to $\frac{1}{12}$ of the dif-
13 ference between—

14 “(i) the total amount of all monthly premiums
15 paid by the individual under this section during the
16 previous calendar year; and

17 “(ii) the total amount of all such premiums
18 which would have been paid by the individual during
19 the previous calendar year if the amount of the indi-
20 vidual’s modified adjusted gross income initially de-
21 termined under paragraph (3) were equal to the ac-
22 tual amount of the individual’s modified adjusted
23 gross income determined under this paragraph.

24 “(B) In the case of an individual who is not enrolled
25 under this part for any calendar year for which the indi-

1 vidual’s monthly premium under this section for months
 2 during the year would be increased pursuant to subpara-
 3 graph (A) if the individual were enrolled under this part
 4 for the year, the Secretary may take such steps as the
 5 Secretary considers appropriate to recover from the indi-
 6 vidual the total amount by which the individual’s monthly
 7 premium for months during the year would have been in-
 8 creased under subparagraph (A) if the individual were en-
 9 rolled under this part for the year.

10 “(C) In the case of a deceased individual for whom
 11 the amount of the monthly premium under this section
 12 for months in a year would have been decreased pursuant
 13 to subparagraph (A) if the individual were not deceased,
 14 the Secretary shall make a payment to the individual’s
 15 surviving spouse (or, in the case of an individual who does
 16 not have a surviving spouse, to the individual’s estate) in
 17 an amount equal to the difference between—

18 “(i) the total amount by which the individual’s
 19 premium would have been decreased for all months
 20 during the year pursuant to subparagraph (A); and

21 “(ii) the amount (if any) by which the individ-
 22 ual’s premium was decreased for months during the
 23 year pursuant to subparagraph (A).

24 “(5) In this subsection, the following definitions
 25 apply:

1 “(A) The term ‘modified adjusted gross income’
2 means adjusted gross income (as defined in section
3 62 of the Internal Revenue Code of 1986)—

4 “(i) determined without regard to sections
5 135, 911, 931, and 933 of such Code, and

6 “(ii) increased by the amount of interest
7 received or accrued by the taxpayer during the
8 taxable year which is exempt from tax under
9 such Code.

10 “(B) The term ‘threshold amount’ means—

11 “(i) except as otherwise provided in this
12 paragraph, \$75,000,

13 “(ii) \$125,000, in the case of a joint re-
14 turn (as defined in section 7701(a)(38) of such
15 Code), and

16 “(iii) zero in the case of a taxpayer who—

17 “(I) is married at the close of the tax-
18 able year but does not file a joint return
19 (as so defined) for such year, and

20 “(II) does not live apart from his
21 spouse at all times during the taxable
22 year.”.

23 (b) CONFORMING AMENDMENT.—Section 1839(f)
24 (42 U.S.C. 1395r(f)) is amended by striking “if an indi-
25 vidual” and inserting the following: “if an individual

1 (other than an individual subject to an increase in the
2 monthly premium under this section pursuant to sub-
3 section (h))”.

4 (c) REPORTING REQUIREMENTS FOR SECRETARY OF
5 THE TREASURY.—

6 (1) IN GENERAL.—Subsection (l) of section
7 6103 of the Internal Revenue Code of 1986 (relating
8 to confidentiality and disclosure of returns and re-
9 turn information) is amended by adding at the end
10 the following new paragraph:

11 “(15) DISCLOSURE OF RETURN INFORMATION
12 TO CARRY OUT INCOME-RELATED REDUCTION IN
13 MEDICARE PART B PREMIUM.—

14 “(A) IN GENERAL.—The Secretary may,
15 upon written request from the Secretary of
16 Health and Human Services, disclose to officers
17 and employees of the Health Care Financing
18 Administration return information with respect
19 to a taxpayer who is required to pay a monthly
20 premium under section 1839 of the Social Secu-
21 rity Act. Such return information shall be lim-
22 ited to—

23 “(i) taxpayer identity information
24 with respect to such taxpayer,

1 “(ii) the filing status of such tax-
2 payer,

3 “(iii) the adjusted gross income of
4 such taxpayer,

5 “(iv) the amounts excluded from such
6 taxpayer’s gross income under sections 135
7 and 911,

8 “(v) the interest received or accrued
9 during the taxable year which is exempt
10 from the tax imposed by chapter 1 to the
11 extent such information is available, and

12 “(vi) the amounts excluded from such
13 taxpayer’s gross income by sections 931
14 and 933 to the extent such information is
15 available.

16 “(B) RESTRICTION ON USE OF DISCLOSED
17 INFORMATION.—Return information disclosed
18 under subparagraph (A) may be used by offi-
19 cers and employees of the Health Care Financ-
20 ing Administration only for the purposes of,
21 and to the extent necessary in, establishing the
22 appropriate monthly premium under section
23 1839 of the Social Security Act.”

24 (2) CONFORMING AMENDMENT.—Paragraphs
25 (3)(A) and (4) of section 6103(p) of such Code are

1 each amended by striking “or (14)” each place it ap-
 2 pears and inserting “(14), or (15)”.

3 (d) EFFECTIVE DATE.—The amendments made by
 4 subsections (a) and (b) shall apply to the monthly pre-
 5 mium under section 1839 of the Social Security Act for
 6 months beginning with January 1997.

7 **PART 3—ADMINISTRATION AND BILLING OF**
 8 **LABORATORY SERVICES**

9 **SEC. 15621. ADMINISTRATIVE SIMPLIFICATION FOR LAB-**
 10 **ORATORY SERVICES.**

11 (a) IN GENERAL.—Not later than 1 year after the
 12 date of the enactment of this Act, the Secretary of Health
 13 and Human Services (in accordance with the process de-
 14 scribed in subsection (b)) shall adopt uniform coverage,
 15 administration, and payment policies for clinical diag-
 16 nostic laboratory tests under part B of the medicare pro-
 17 gram.

18 (b) PROCESS FOR ADOPTION OF POLICIES.—The
 19 Secretary shall adopt uniform policies under subsection
 20 (a) in accordance with the following process:

21 (1) The Secretary shall select from carriers
 22 with whom the Secretary has a contract under part
 23 B during 1995 15 medical directors, who will meet
 24 and develop recommendations for such uniform poli-
 25 cies. The medical directors selected shall represent

1 various geographic areas and have a varied range of
2 experience in relevant medical fields, including pa-
3 thology and clinical laboratory practice.

4 (2) The medical directors selected under para-
5 graph (1) shall consult with independent experts in
6 each major discipline of clinical laboratory medicine,
7 including clinical laboratory personnel, bioanalysts,
8 pathologists, and practicing physicians. The medical
9 directors shall also solicit comments from other indi-
10 viduals and groups who wish to participate, includ-
11 ing consumers and other affected parties. This proc-
12 ess shall be conducted as a negotiated rulemaking
13 under title 5, United States Code.

14 (3) Under the negotiated rulemaking, the rec-
15 ommendations for uniform policies shall be designed
16 to simplify and reduce unnecessary administrative
17 burdens in connection with the following:

18 (A) Beneficiary information required to be
19 submitted with each claim.

20 (B) Physicians' obligations regarding docu-
21 mentation requirements and recordkeeping.

22 (C) Procedures for filing claims and for
23 providing remittances by electronic media.

24 (D) The performance of post-payment re-
25 view of test claims.

1 (E) The prohibition of the documentation
2 of medical necessity except when determined to
3 be appropriate after identification of aberrant
4 utilization pattern through focused medical re-
5 view.

6 (F) Beneficiary responsibility for payment.

7 (4) During the pendency of the adoption by the
8 Secretary of the uniform policies, fiscal
9 intermediaries and carriers under the medicare pro-
10 gram may not implement any new requirement relat-
11 ing to the submission of a claim for clinical diag-
12 nostic laboratory tests retroactive to January 1,
13 1995, and carriers may not initiate any new cov-
14 erage, administrative, or payment policy unless the
15 policy promotes the goal of administrative simplifica-
16 tion of requirements imposed on clinical laboratories
17 in accordance with the Secretary's promulgation of
18 the negotiated rulemaking.

19 (5) Not later than 6 months after the date of
20 the enactment of this Act, the medical directors shall
21 submit their recommendations to the Secretary, and
22 the Secretary shall publish the recommendations and
23 solicit public comment using negotiated rulemaking
24 in accordance with title 5, United States Code. The
25 Secretary shall publish final uniform policies for cov-

1 erage, administration, and payment of claims for
 2 clinical diagnostic laboratory tests, effective after the
 3 expiration of the 180-day period which begins on the
 4 date of publication.

5 (6) After the publication of the final uniform
 6 policies, the Secretary shall implement identical uni-
 7 form documentation and processing policies for all
 8 clinical diagnostic laboratory tests paid under the
 9 medicare program through fiscal intermediaries or
 10 carriers.

11 (c) OPTIONAL SELECTION OF SINGLE CARRIER.—Ef-
 12 fective for claims submitted after the expiration of the 90-
 13 day period which begins on the date of the enactment of
 14 this Act, an independent laboratory may select a single
 15 carrier for the processing of all of its claims for payment
 16 under part B of the medicare program, without regard to
 17 the location where the laboratory or the patient or pro-
 18 vider involved resides or conducts business. Such election
 19 of a single carrier shall be made by the clinical laboratory
 20 and an agreement made between the carrier and the lab-
 21 oratory shall be forwarded to the Secretary of Health and
 22 Human Services. Nothing in this subsection shall be con-
 23 strued to require a laboratory to select a single carrier
 24 under this subsection.

1 **SEC. 15622. RESTRICTIONS ON DIRECT BILLING FOR LAB-**
 2 **ORATORY SERVICES.**

3 (a) REQUIREMENT FOR DIRECT BILLING.—Section
 4 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at
 5 the end the following new paragraph:

6 “(7)(A) Effective for services furnished on or October
 7 1, 1996, an individual or entity that performs clinical lab-
 8 oratory diagnostic tests shall not present or cause to be
 9 presented a claim, bill, or demand for payment to any per-
 10 son, other than the individual receiving such services or
 11 the health plan designated by such person, except that (i)
 12 in the case of a test performed by one laboratory at the
 13 request of another laboratory, which meets the require-
 14 ments of clause (i), (ii), or (iii) of paragraph (5)(A), pay-
 15 ment may be made to the requesting laboratory, and (ii)
 16 the Secretary may by regulation establish appropriate ex-
 17 ceptions to the requirement of this subparagraph.

18 “(B)(i) Any person that collects any amounts that
 19 were billed in violation of paragraph (7)(A) above shall
 20 be liable for such amounts to the person from whom such
 21 amounts were collected.

22 “(ii) Any person that furnishes clinical laboratory
 23 services for which payment is made under paragraph
 24 (1)(D)(i) or paragraph (2)(D)(i) that knowingly violates
 25 subparagraph (A) is subject to a civil money penalty of
 26 not more than \$10,000 for each such violation. The provi-

1 sions of section 1128A (other than subsections (a) and
2 (b)) shall apply to a civil money penalty under this para-
3 graph in the same manner as such provisions apply with
4 respect to a penalty or proceeding under section 1128A(a).

5 “(iii)(I) Any individual or entity that the Secretary
6 determines has repeatedly violated subparagraph (A) may
7 be excluded from participation in any Federal health care
8 program. The provisions of section 1128A (other than
9 subsections (a) and (b)) shall apply to an exclusion under
10 this paragraph in the same manner as such provisions
11 apply with respect to a penalty or proceeding under section
12 1128A(a).

13 “(II) The provisions of section 1128(e) of the Social
14 Security Act shall apply to any exclusion under clause
15 (iii)(I) in the same manner as such provisions apply to
16 a proceeding under section 1128.

17 “(iv) If the Secretary finds, after a reasonable notice
18 and opportunity for a hearing, that a laboratory which
19 holds a certificate pursuant to section 353 of the Public
20 Health Service Act has on a repeated basis violated sub-
21 paragraph (A), the Secretary may suspend, revoke, or
22 limit such certification in accordance with the procedures
23 established in section 353(k) of Public Health Service Act.

24 “(C) For purposes of this paragraph, the following
25 definitions shall apply:

1 “(i) The term ‘Federal health care program’
2 means—

3 “(I) any plan or program that provides
4 health benefits, whether directly, through insur-
5 ance, or otherwise, which is funded, in whole or
6 in part, by the United States Government; or

7 “(II) any State health care program, as
8 defined in section 1128(h).

9 “(ii) The term ‘health plan’ means any hospital
10 or medical service policy or certificate, hospital or
11 medical service plan contract, or health maintenance
12 organization contract offered by an insurer, except
13 that such term does not include any of the following:

14 “(I) Coverage only for accident, dental, vi-
15 sion, disability income, or long-term care insur-
16 ance, or any combination thereof.

17 “(II) Medicare supplemental health insur-
18 ance.

19 “(III) Coverage issued as a supplement to
20 liability insurance.

21 “(IV) Liability insurance, including general
22 liability insurance and automobile liability in-
23 surance.

24 “(V) Worker’s compensation or similar in-
25 surance.

1 “(VI) Automobile medical-payment insur-
2 ance.

3 “(VII) Coverage for a specified disease or
4 illness.

5 “(VIII) A hospital or fixed indemnity pol-
6 icy.

7 (b) LOOK BACK PROVISIONS TO ASSURE SAVINGS.—

8 (1) IN GENERAL.—Section 1833(h)(4)(B) (42
9 U.S.C. 1395l(h)(4)(B)), as amended by section
10 15604(b), is amended—

11 (A) in clause (vii), by striking “and” at the
12 end;

13 (B) in clause (viii)—

14 (i) by inserting “and before January
15 1, 2000,” after “1996,” and

16 (ii) by striking the period at the end
17 and inserting “, and”; and

18 (C) by adding at the end the following new
19 clause:

20 “(ix) after December 31, 1999, is equal to such
21 percentage of such median as the Secretary estab-
22 lishes under paragraph (8)(B), or, if the Secretary
23 does not act under paragraph (8)(B), is equal to 65
24 percent of such median.”.

1 (2) PROCESS FOR REDUCTIONS.—Section
2 1833(h) (42 U.S.C. 1395l(h)), as amended by sub-
3 section (a), is amended by adding at the end the fol-
4 lowing new paragraph:

5 “(8)(A) On July 31, 1999, the Secretary shall esti-
6 mate—

7 “(i) the amount of expenditures under this sec-
8 tion for clinical diagnostic laboratory tests which will
9 be made in the period from January 1, 1997,
10 through September 30, 2002, and

11 “(ii) the amount of expenditures which would
12 have been made under this section for clinical diag-
13 nostic laboratory tests in the period from January 1,
14 1997, through September 30, 2002, if paragraph (7)
15 had not been enacted.

16 “(B) If the amount estimated under subparagraph
17 (A)(i) is greater than 97 percent of the amount estimated
18 under subparagraph (A)(ii), the Secretary shall establish
19 a limitation amount under paragraph (4)(B)(ix) such that,
20 when such limitation amount is considered, the amount
21 estimated under subparagraph (A)(i) is 97 percent of the
22 amount estimated under subparagraph (A)(ii).

23 “(C) The Director of the Congressional Budget Office
24 (hereafter in this subparagraph referred to as the ‘Direc-
25 tor’) shall—

1 “(i) independently estimate the amounts speci-
2 fied in subparagraph (A) and compute any limitation
3 amount required under subparagraph (B), and

4 “(ii) submit a report on such estimates and
5 computation to Congress not later than August 31,
6 1999.

7 The Secretary shall provide the Director with such data
8 as the Director reasonably requires to prepare such esti-
9 mates and computation.”.

10 **PART 4—QUALITY STANDARDS FOR DURABLE**

11 **MEDICAL EQUIPMENT**

12 **SEC. 15631. RECOMMENDATIONS FOR QUALITY STANDARDS**

13 **FOR DURABLE MEDICARE EQUIPMENT.**

14 (a) APPOINTMENT OF TASK FORCE BY SEC-
15 RETARY.—

16 (1) IN GENERAL.—The Secretary of Health and
17 Human Services shall establish a broadly based task
18 force to develop recommendations for quality stand-
19 ards for durable medical equipment under part B of
20 the medicare program.

21 (2) COMPOSITION.—The task force shall include
22 individuals selected by the Secretary from represent-
23 atives of suppliers of items of durable medical equip-
24 ment under part B, consumers, and other users of
25 such equipment. In appointing members, the Sec-

1 retary shall assure representation from various geo-
2 graphic regions of the United States.

3 (3) NO COMPENSATION FOR SERVICE.—Mem-
4 bers of the task force shall not receive any com-
5 pensation for service on the task force.

6 (4) TERMINATION.—The task force shall termi-
7 nate 30 days after it submits the report described in
8 subsection (b).

9 (b) REPORT.—Not later than 1 year after the date
10 of the enactment of this Act, the task force established
11 under subsection (a) shall submit to the Secretary its rec-
12 ommendations for quality standards for durable medicare
13 equipment under part B of the medicare program.

14 **Subtitle H—Provisions Relating to**
15 **Medicare Parts A and B**

16 **PART 1—PAYMENTS FOR HOME HEALTH**
17 **SERVICES**

18 **SEC. 15701. PAYMENT FOR HOME HEALTH SERVICES.**

19 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et
20 seq.), as amended by section 15106, is amended by adding
21 at the end the following new section:

22 “PAYMENT FOR HOME HEALTH SERVICES

23 “SEC. 1894. (a) IN GENERAL.—

24 “(1) PER VISIT PAYMENTS.—Subject to sub-
25 section (c), the Secretary shall make per visit pay-
26 ments beginning with fiscal year 1997 to a home

1 health agency in accordance with this section for
 2 each type of home health service described in para-
 3 graph (2) furnished to an individual who at the time
 4 the service is furnished is under a plan of care by
 5 the home health agency under this title (without re-
 6 gard to whether or not the item or service was fur-
 7 nished by the agency or by others under arrange-
 8 ment with them made by the agency, or otherwise).

9 “(2) TYPES OF SERVICES.—The types of home
 10 health services described in this paragraph are the
 11 following:

12 “(A) Part-time or intermittent nursing
 13 care provided by or under the supervision of a
 14 registered professional nurse.

15 “(B) Physical therapy.

16 “(C) Occupational therapy.

17 “(D) Speech-language pathology services.

18 “(E) Medical social services under the di-
 19 rection of a physician.

20 “(F) To the extent permitted in regula-
 21 tions, part-time or intermittent services of a
 22 home health aide who has successfully com-
 23 pleted a training program approved by the Sec-
 24 retary.

1 “(b) ESTABLISHMENT OF PER VISIT RATE FOR
2 EACH TYPE OF SERVICES.—

3 “(1) IN GENERAL.—The Secretary shall, sub-
4 ject to paragraph (3), establish a per visit payment
5 rate for a home health agency in an area for each
6 type of home health service described in subsection
7 (a)(2). Such rate shall be equal to the national per
8 visit payment rate determined under paragraph (2)
9 for each such type, except that the labor-related por-
10 tion of such rate shall be adjusted by the area wage
11 index applicable under section 1886(d)(3)(E) for the
12 area in which the agency is located (as determined
13 without regard to any reclassification of the area
14 under section 1886(d)(8)(B) or a decision of the
15 Medicare Geographic Classification Review Board or
16 the Secretary under section 1886(d)(10) for cost re-
17 porting periods beginning after October 1, 1995).

18 “(2) NATIONAL PER VISIT PAYMENT RATE.—
19 The national per visit payment rate for each type of
20 service described in subsection (a)(2)—

21 “(A) for fiscal year 1997, is an amount
22 equal to the national average amount paid per
23 visit under this title to home health agencies for
24 such type of service during the most recent 12-
25 month cost reporting period ending on or before

1 June 30, 1994, increased (in a compounded
2 manner) by the home health market basket per-
3 centage increase for fiscal years 1995, 1996,
4 and 1997; and

5 “(B) for each subsequent fiscal year, is an
6 amount equal to the national per visit payment
7 rate in effect for the preceding fiscal year, in-
8 creased by the home health market basket per-
9 centage increase for such subsequent fiscal year
10 minus 2 percentage points.

11 “(3) REBASING OF RATES.—The Secretary
12 shall provide for an update to the national per visit
13 payment rates under this subsection for cost report-
14 ing periods beginning not later than the first day of
15 the fifth fiscal year which begins after fiscal year
16 1997, and not later than every 5 years thereafter, to
17 reflect the most recent available data.

18 “(4) HOME HEALTH MARKET BASKET PER-
19 CENTAGE INCREASE.—For purposes of this sub-
20 section, the term ‘home health market basket per-
21 centage increase’ means, with respect to a fiscal
22 year, a percentage (estimated by the Secretary be-
23 fore the beginning of the fiscal year) determined and
24 applied with respect to the types of home health
25 services described in subsection (a)(2) in the same

1 manner as the market basket percentage increase
 2 under section 1886(b)(3)(B)(iii) is determined and
 3 applied to inpatient hospital services for the fiscal
 4 year.

5 “(c) PER EPISODE LIMIT.—

6 “(1) AGGREGATE LIMIT.—

7 “(A) IN GENERAL.—Except as provided in
 8 paragraph (2), a home health agency may not
 9 receive aggregate per visit payments under sub-
 10 section (a) for a fiscal year in excess of an
 11 amount equal to the sum of the following prod-
 12 ucts determined for each case-mix category for
 13 which the agency receives payments:

14 “(i) The number of episodes of each
 15 case-mix category during the fiscal year;
 16 multiplied by

17 “(ii) the per episode limit determined
 18 for such case-mix category for such fiscal
 19 year.

20 “(B) ESTABLISHMENT OF PER EPISODE
 21 LIMITS.—

22 “(i) IN GENERAL.—The per episode
 23 limit for a fiscal year for any case-mix cat-
 24 egory for the area in which a home health
 25 agency is located is equal to—

1 “(I) the mean number of visits
2 for each type of home health service
3 described in subsection (a)(2) fur-
4 nished during an episode of such case-
5 mix category in such area during fis-
6 cal year 1994, adjusted by the case-
7 mix adjustment factor determined in
8 clause (ii) for the fiscal year involved;
9 multiplied by

10 “(II) the per visit payment rate
11 established under subsection (b) for
12 such type of home health service for
13 the fiscal year for which the deter-
14 mination is being made.

15 “(ii) CASE MIX ADJUSTMENT FAC-
16 TOR.—For purposes of clause (i), the case-
17 mix adjustment factor for a year is the
18 factor determined by the Secretary to as-
19 sure that aggregate payments for home
20 health services under this section during
21 the year will not exceed the payment for
22 such services during the previous year as a
23 result of changes in the number and type
24 of home health visits within case-mix cat-
25 egories over the previous year.

1 “(iii) REBASING OF PER EPISODE
2 AMOUNTS.—Beginning with fiscal year
3 1999 and every 2 years thereafter, the Sec-
4 retary shall revise the mean number of
5 home health visits determined under clause
6 (i)(I) for each type of home health service
7 visit described in subsection (a)(2) fur-
8 nished during an episode in a case-mix cat-
9 egory to reflect the most recently available
10 data on the number of visits.

11 “(iv) DETERMINATION OF APPLICA-
12 BLE AREA.—For purposes of determining
13 per episode limits under this subpara-
14 graph, the area in which a home health
15 agency is considered to be located shall be
16 such area as the Secretary finds appro-
17 priate for purposes of this subparagraph.

18 “(C) CASE-MIX CATEGORY.—For purposes
19 of this paragraph, the term ‘case-mix category’
20 means each of the 18 case-mix categories estab-
21 lished under the Phase II Home Health Agency
22 Prospective Payment Demonstration Project
23 conducted by the Health Care Financing Ad-
24 ministration. The Secretary may develop an al-

1 ternate methodology for determining case-mix
2 categories.

3 “(D) EPISODE.—

4 “(i) IN GENERAL.—For purposes of
5 this paragraph, the term ‘episode’ means
6 the continuous 120-day period that—

7 “(I) begins on the date of an in-
8 dividual’s first visit for a type of home
9 health service described in subsection
10 (a)(2) for a case-mix category, and

11 “(II) is immediately preceded by
12 a 60-day period in which the individ-
13 ual did not receive visits for a type of
14 home health service described in sub-
15 section (a)(2).

16 “(ii) TREATMENT OF EPISODES SPAN-
17 NING COST REPORTING PERIODS.—The
18 Secretary shall provide for such rules as
19 the Secretary considers appropriate regard-
20 ing the treatment of episodes under this
21 paragraph which begin during a cost re-
22 porting period and end in a subsequent
23 cost reporting period.

24 “(E) EXEMPTIONS AND EXCEPTIONS.—

25 The Secretary may provide for exemptions and

1 exceptions to the limits established under this
 2 paragraph for a fiscal year as the Secretary
 3 deems appropriate, to the extent such exemp-
 4 tions and exceptions do not result in greater
 5 payments under this section than the exemp-
 6 tions and exceptions provided under section
 7 1861(v)(1)(L)(ii) in fiscal year 1994, increased
 8 by the home health market basket percentage
 9 increase for the fiscal year involved (as defined
 10 in subsection (b)(4)).

11 “(2) RECONCILIATION OF AMOUNTS.—

12 “(A) OVERPAYMENTS TO HOME HEALTH
 13 AGENCIES.—Subject to subparagraph (B), if a
 14 home health agency has received aggregate per
 15 visit payments under subsection (a) for a fiscal
 16 year in excess of the amount determined under
 17 paragraph (1) with respect to such home health
 18 agency for such fiscal year, the Secretary shall
 19 reduce payments under this section to the home
 20 health agency in the following fiscal year in
 21 such manner as the Secretary considers appro-
 22 priate (including on an installment basis) to re-
 23 capture the amount of such excess.

1 “(B) EXCEPTION FOR HOME HEALTH
2 SERVICES FURNISHED OVER A PERIOD GREAT-
3 ER THAN 165 DAYS.—

4 “(i) IN GENERAL.—For purposes of
5 subparagraph (A), the amount of aggre-
6 gate per visit payments determined under
7 subsection (a) shall not include payments
8 for home health visits furnished to an indi-
9 vidual on or after a continuous period of
10 more than 165 days after an individual be-
11 gins an episode described in subsection
12 (c)(1)(D) (if such period is not interrupted
13 by the beginning of a new episode).

14 “(ii) REQUIREMENT OF CERTIFI-
15 CATION.—Clause (i) shall not apply if the
16 agency has not obtained a physician’s cer-
17 tification with respect to the individual re-
18 quiring such visits that includes a state-
19 ment that the individual requires such con-
20 tinued visits, the reason for the need for
21 such visits, and a description of such serv-
22 ices furnished during such visits.

23 “(C) SHARE OF SAVINGS.—

24 “(i) BONUS PAYMENTS.—If a home
25 health agency has received aggregate per

1 visit payments under subsection (a) for a
 2 fiscal year in an amount less than the
 3 amount determined under paragraph (1)
 4 with respect to such home health agency
 5 for such fiscal year, the Secretary shall pay
 6 such home health agency a bonus payment
 7 equal to 50 percent of the difference be-
 8 tween such amounts in the following fiscal
 9 year, except that the bonus payment may
 10 not exceed 5 percent of the aggregate per
 11 visit payments made to the agency for the
 12 year.

13 “(ii) INSTALLMENT BONUS PAY-
 14 MENTS.—The Secretary may make install-
 15 ment payments during a fiscal year to a
 16 home health agency based on the estimated
 17 bonus payment that the agency would be
 18 eligible to receive with respect to such fis-
 19 cal year.

20 “(d) MEDICAL REVIEW PROCESS.—The Secretary
 21 shall implement a medical review process (with a particu-
 22 lar emphasis on fiscal years 1997 and 1998) for the sys-
 23 tem of payments described in this section that shall pro-
 24 vide an assessment of the pattern of care furnished to in-
 25 dividuals receiving home health services for which pay-

1 ments are made under this section to ensure that such
 2 individuals receive appropriate home health services. Such
 3 review process shall focus on low-cost cases described in
 4 subsection (e)(3) and cases described in subsection
 5 (c)(2)(B) and shall require recertification by
 6 intermediaries at 30, 60, 90, 120, and 165 days into an
 7 episode described in subsection (c)(1)(D).

8 “(e) ADJUSTMENT OF PAYMENTS TO AVOID CIR-
 9 CUMVENTION OF LIMITS.—

10 “(1) IN GENERAL.—The Secretary shall provide
 11 for appropriate adjustments to payments to home
 12 health agencies under this section to ensure that
 13 agencies do not circumvent the purpose of this sec-
 14 tion by—

15 “(A) discharging patients to another home
 16 health agency or similar provider;

17 “(B) altering corporate structure or name
 18 to avoid being subject to this section or for the
 19 purpose of increasing payments under this title;
 20 or

21 “(C) undertaking other actions considered
 22 unnecessary for effective patient care and in-
 23 tended to achieve maximum payments under
 24 this title.

1 “(2) TRACKING OF PATIENTS THAT SWITCH
2 HOME HEALTH AGENCIES DURING EPISODE.—

3 “(A) DEVELOPMENT OF SYSTEM.—The
4 Secretary shall develop a system that tracks
5 home health patients that receive home health
6 services described in subsection (a)(2) from
7 more than 1 home health agency during an epi-
8 sode described in subsection (c)(1)(D).

9 “(B) ADJUSTMENT OF PAYMENTS.—The
10 Secretary shall adjust payments under this sec-
11 tion to each home health agency that furnishes
12 an individual with a type of home health service
13 described in subsection (a)(2) to ensure that
14 aggregate payments on behalf of such individual
15 during such episode do not exceed the amount
16 that would be paid under this section if the in-
17 dividual received such services from a single
18 home health agency.

19 “(3) LOW-COST CASES.—The Secretary shall
20 develop a system designed to adjust payments to a
21 home health agency for a fiscal year to eliminate any
22 increase in growth of the percentage of low-cost epi-
23 sodes for which home health services are furnished
24 by the agency over such percentage determined for
25 the agency for the 12-month cost reporting period

1 ending on June 30, 1994. The Secretary shall define
 2 a low-cost episode in a manner that provides that a
 3 home health agency has an incentive to be cost effi-
 4 cient in delivering home health services and that the
 5 volume of such services does not increase as a result
 6 of factors other than patient needs.

7 “(f) REPORT BY MEDICARE PAYMENT REVIEW COM-
 8 MISSION.—During the first 3 years in which payments are
 9 made under this section, the Medicare Payment Review
 10 Commission shall annually submit a report to Congress
 11 on the effectiveness of the payment methodology estab-
 12 lished under this section that shall include recommenda-
 13 tions regarding the following:

14 “(1) Case-mix and volume increases.

15 “(2) Quality monitoring of home health agency
 16 practices.

17 “(3) Whether a capitated payment for home
 18 care patients receiving care during a continuous pe-
 19 riod exceeding 165 days is warranted.

20 “(4) Whether public providers of service are
 21 adequately reimbursed.

22 “(5) The adequacy of the exemptions and ex-
 23 ceptions to the limits provided under subsection
 24 (c)(1)(E).

1 “(6) The appropriateness of the methods pro-
2 vided under this section to adjust the per episode
3 limits and annual payment updates to reflect
4 changes in the mix of services, number of visits, and
5 assignment to case categories to reflect changing
6 patterns of home health care.

7 “(7) The geographic areas used to determine
8 the per episode limits.

9 “(g) NO EFFECT ON NON-MEDICARE SERVICES.—
10 Nothing in this section may be construed to affect the pro-
11 vision of or payment for home health services for which
12 payment is not made under this title.”.

13 (b) PAYMENT FOR PROSTHETICS AND ORTHOTICS
14 UNDER PART A.—Section 1814(k) (42 U.S.C. 1395f(k))
15 is amended—

16 (1) by inserting “and prosthetics and orthotics”
17 after “durable medical equipment”; and

18 (2) by inserting “and 1834(h), respectively”
19 after “1834(a)(1)”.

20 (c) CONFORMING AMENDMENTS.—

21 (1) PAYMENTS UNDER PART A.—Section
22 1814(b) (42 U.S.C. 1395f(b)), as amended by sec-
23 tion 15522(b), is amended in the matter preceding
24 paragraph (1) by striking “1888 and 1888A” and
25 inserting “1888, 1888A, and 1894”.

1 (2) TREATMENT OF ITEMS AND SERVICES PAID
2 UNDER PART B.—

3 (A) PAYMENTS UNDER PART B.—Section
4 1833(a)(2) (42 U.S.C. 1395l(a)(2)) is amend-
5 ed—

6 (i) by amending subparagraph (A) to
7 read as follows:

8 “(A) with respect to home health serv-
9 ices—

10 “(i) that are a type of home health
11 service described in section 1894(a)(2),
12 and which are furnished to an individual
13 who (at the time the item or service is fur-
14 nished) is under a plan of care of a home
15 health agency, the amount determined
16 under section 1894; or

17 “(ii) that are not described in clause
18 (i) (other than a covered osteoporosis
19 drug) (as defined in section 1861(kk)), the
20 lesser of—

21 “(I) the reasonable cost of such
22 services, as determined under section
23 1861(v), or

24 “(II) the customary charges with
25 respect to such services;”.

1 (ii) by striking “and” at the end of
2 subparagraph (E);

3 (iii) by adding “and” at the end of
4 subparagraph (F); and

5 (iv) by adding at the end the following
6 new subparagraph:

7 “(G) with respect to items and services de-
8 scribed in section 1861(s)(10)(A), the lesser
9 of—

10 “(i) the reasonable cost of such serv-
11 ices, as determined under section 1861(v),
12 or

13 “(ii) the customary charges with re-
14 spect to such services,

15 or, if such services are furnished by a public
16 provider of services, or by another provider
17 which demonstrates to the satisfaction of the
18 Secretary that a significant portion of its pa-
19 tients are low-income (and requests that pay-
20 ment be made under this provision), free of
21 charge or at nominal charges to the public, the
22 amount determined in accordance with section
23 1814(b)(2);”.

24 (B) REQUIRING PAYMENT FOR ALL ITEMS
25 AND SERVICES TO BE MADE TO AGENCY.—

1 (i) IN GENERAL.—The first sentence
 2 of section 1842(b)(6) (42 U.S.C.
 3 1395u(b)(6)), as amended by section
 4 15525(a)(1), is amended—

5 (I) by striking “and (E)” and in-
 6 serting “(E)”; and

7 (II) by striking the period at the
 8 end and inserting the following: “,
 9 and (F) in the case of types of home
 10 health services described in section
 11 1894(a)(2) furnished to an individual
 12 who (at the time the item or service is
 13 furnished) is under a plan of care of
 14 a home health agency, payment shall
 15 be made to the agency (without re-
 16 gard to whether or not the item or
 17 service was furnished by the agency,
 18 by others under arrangement with
 19 them made by the agency, or other-
 20 wise).”.

21 (ii) CONFORMING AMENDMENT.—Sec-
 22 tion 1832(a)(1) (42 U.S.C. 1395k(a)(1)),
 23 as amended by section 15525(a)(3), is
 24 amended by striking “section
 25 1842(b)(6)(E);” and inserting “subpara-

1 graphs (E) and (F) of section
2 1842(b)(6);”.

3 (C) EXCLUSIONS FROM COVERAGE.—Sec-
4 tion 1862(a) (42 U.S.C. 1395y(a)), as amended
5 by section 15525(a)(2) and section 15609B(a),
6 is amended—

7 (i) by striking “or” at the end of
8 paragraph (16);

9 (ii) by striking the period at the end
10 of paragraph (17) and inserting “; or”;
11 and

12 (iii) by adding at the end the follow-
13 ing new paragraph:

14 “(18) where such expenses are for home health
15 services furnished to an individual who is under a
16 plan of care of the home health agency if the claim
17 for payment for such services is not submitted by
18 the agency.”.

19 (3) SUNSET OF REASONABLE COST LIMITA-
20 TIONS.—Section 1861(v)(1)(L) (42 U.S.C.
21 1395x(v)(1)(L)) is amended by adding at the end
22 the following new clause:

23 “(iv) This subparagraph shall apply only to services
24 furnished by home health agencies during cost reporting
25 periods ending on or before September 30, 1996.”.

1 (d) LIMITATION ON PART A COVERAGE.—

2 (1) IN GENERAL.—Section 1812(a)(3) (42
3 U.S.C. 1395d(a)(3)) is amended by striking the
4 semicolon and inserting “for up to 165 days during
5 any spell of illness;”.

6 (2) CONFORMING AMENDMENT.—Section
7 1812(b) (42 U.S.C. 1395d(b)) is amended—

8 (A) by striking “or” at the end of para-
9 graph (2),

10 (B) by striking the period at the end of
11 paragraph (3) and inserting “; or”, and

12 (C) by adding at the end the following new
13 paragraph:

14 “(4) home health services furnished to the indi-
15 vidual during such spell after such services have
16 been furnished to the individual for 165 days during
17 such spell.”.

18 (3) EXCLUSION OF ADDITIONAL PART B COSTS
19 FROM DETERMINATION OF PART B MONTHLY PRE-
20 MIUM.—Section 1839(a) (42 U.S.C. 1395r(a)) is
21 amended—

22 (A) in the second sentence of paragraph
23 (1), by striking “enrollees.” and inserting “en-
24 rollees (except as provided in paragraph (5)).”;
25 and

1 (B) by adding at the end the following new
2 paragraph:

3 “(5) In estimating the benefits and administrative
4 costs which will be payable from the Federal Supple-
5 mentary Medical Insurance Trust Fund for a year (begin-
6 ning with 1996), the Secretary shall exclude an estimate
7 of any benefits and costs attributable to home health serv-
8 ices for which payment would have been made under part
9 A during the year but for paragraph (4) of section
10 1812(b).”.

11 (4) EFFECTIVE DATE.—The amendments made
12 by this subsection shall apply to spells of illness be-
13 ginning on or after October 1, 1995.

14 (e) EFFECTIVE DATE.—Except as provided in sub-
15 section (d)(4), the amendments made by this section shall
16 apply to cost reporting periods beginning on or after Octo-
17 ber 1, 1996.

18 **SEC. 15702. MAINTAINING SAVINGS RESULTING FROM TEM-**
19 **PORARY FREEZE ON PAYMENT INCREASES**
20 **FOR HOME HEALTH SERVICES.**

21 (a) BASING UPDATES TO PER VISIT COST LIMITS ON
22 LIMITS FOR FISCAL YEAR 1993.—Section
23 1861(v)(1)(L)(iii) (42 U.S.C. 1395x(v)(1)(L)(iii)) is
24 amended by adding at the end the following sentence: “In
25 establishing limits under this subparagraph, the Secretary

1 may not take into account any changes in the costs of
2 the provision of services furnished by home health agencies
3 with respect to cost reporting periods which began on or
4 after July 1, 1994, and before July 1, 1996.”.

5 (b) NO EXCEPTIONS PERMITTED BASED ON AMEND-
6 MENT.—The Secretary of Health and Human Services
7 shall not consider the amendment made by subsection (a)
8 in making any exemptions and exceptions pursuant to sec-
9 tion 1861(v)(1)(L)(ii) of the Social Security Act.

10 **SEC. 15703. EXTENSION OF WAIVER OF PRESUMPTION OF**
11 **LACK OF KNOWLEDGE OF EXCLUSION FROM**
12 **COVERAGE FOR HOME HEALTH AGENCIES.**

13 Section 9305(g)(3) of OBRA–1986, as amended by
14 section 426(d) of the Medicare Catastrophic Coverage Act
15 of 1988 and section 4207(b)(3) of OBRA–1990 (as re-
16 numbered by section 160(d)(4) of the Social Security Act
17 Amendments of 1994), is amended by striking “December
18 31, 1995” and inserting “September 30, 1996”.

19 **SEC. 15704. REPORT ON RECOMMENDATIONS FOR PAY-**
20 **MENTS AND CERTIFICATION FOR HOME**
21 **HEALTH SERVICES OF CHRISTIAN SCIENCE**
22 **PROVIDERS.**

23 Not later than July 1, 1996, the Secretary of Health
24 and Human Services shall submit recommendations to
25 Congress regarding an appropriate methodology for mak-

1 ing payments under the medicare program for home
 2 health services furnished by Christian Science providers
 3 who meet applicable requirements of the First Church of
 4 Christ, Scientist, Boston, Massachusetts, and appropriate
 5 criteria for the certification of such providers for purposes
 6 of the medicare program.

7 **SEC. 15705. EXTENSION OF PERIOD OF HOME HEALTH**
 8 **AGENCY CERTIFICATION.**

9 Section 1891(c)(2)(A) (42 U.S.C. 1395bbb(c)(2)(A))
 10 is amended—

11 (1) by striking “15 months” and inserting “36
 12 months”; and

13 (2) by striking the second sentence and insert-
 14 ing the following: “The Secretary shall establish a
 15 frequency for surveys of home health agencies within
 16 this 36-month interval commensurate with the need
 17 to assure the delivery of quality home health serv-
 18 ices.”.

19 **PART 2—MEDICARE SECONDARY PAYER**
 20 **IMPROVEMENTS**

21 **SEC. 15711. EXTENSION AND EXPANSION OF EXISTING RE-**
 22 **QUIREMENTS.**

23 (a) DATA MATCH.—

24 (1) Section 1862(b)(5)(C) (42 U.S.C.
 25 1395y(b)(5)(C)) is amended by striking clause (iii).

1 (2) Section 6103(l)(12) of the Internal Revenue
2 Code of 1986 is amended by striking subparagraph
3 (F).

4 (b) APPLICATION TO DISABLED INDIVIDUALS IN
5 LARGE GROUP HEALTH PLANS.—

6 (1) IN GENERAL.—Section 1862(b)(1)(B) (42
7 U.S.C. 1395y(b)(1)(B)) is amended—

8 (A) in clause (i), by striking “clause (iv)”
9 and inserting “clause (iii)”,

10 (B) by striking clause (iii), and

11 (C) by redesignating clause (iv) as clause
12 (iii).

13 (2) CONFORMING AMENDMENTS.—Paragraphs
14 (1) through (3) of section 1837(i) (42 U.S.C.
15 1395p(i)) and the second sentence of section
16 1839(b) (42 U.S.C. 1395r(b)) are each amended by
17 striking “1862(b)(1)(B)(iv)” each place it appears
18 and inserting “1862(b)(1)(B)(iii)”.

19 (c) EXPANSION OF PERIOD OF APPLICATION TO IN-
20 DIVIDUALS WITH END STAGE RENAL DISEASE.—Section
21 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

22 (1) in the first sentence, by striking “12-
23 month” each place it appears and inserting “24-
24 month”, and

25 (2) by striking the second sentence.

1 **SEC. 15712. IMPROVEMENTS IN RECOVERY OF PAYMENTS.**

2 (a) PERMITTING RECOVERY AGAINST THIRD PARTY
3 ADMINISTRATORS OF PRIMARY PLANS.—Section
4 1862(b)(2)(B)(ii) (42 U.S.C. 1395y(b)(2)(B)(ii)) is
5 amended—

6 (1) by striking “under this subsection to pay”
7 and inserting “(directly, as a third-party adminis-
8 trator, or otherwise) to make payment”, and

9 (2) by adding at the end the following: “The
10 United States may not recover from a third-party
11 administrator under this clause in cases where the
12 third-party administrator would not be able to re-
13 cover the amount at issue from the employer or
14 group health plan for whom it provides administra-
15 tive services due to the insolvency or bankruptcy of
16 the employer or plan.”.

17 (b) EXTENSION OF CLAIMS FILING PERIOD.—Sec-
18 tion 1862(b)(2)(B) (42 U.S.C. 1395y(b)(2)(B)) is amend-
19 ed by adding at the end the following new clause:

20 “(v) CLAIMS-FILING PERIOD.—Not-
21 withstanding any other time limits that
22 may exist for filing a claim under an em-
23 ployer group health plan, the United
24 States may seek to recover conditional pay-
25 ments in accordance with this subpara-
26 graph where the request for payment is

1 submitted to the entity required or respon-
 2 sible under this subsection to pay with re-
 3 spect to the item or service (or any portion
 4 thereof) under a primary plan within the
 5 3-year period beginning on the date on
 6 which the item or service was furnished.”.

7 (c) EFFECTIVE DATE.—The amendments made by
 8 this section shall apply to items and services furnished on
 9 or after the date of the enactment of this Act.

10 **SEC. 15713. PROHIBITING RETROACTIVE APPLICATION OF**
 11 **POLICY REGARDING ESRD BENEFICIARIES**
 12 **ENROLLED IN PRIMARY PLANS.**

13 For purposes of carrying out section 1862(b)(1)(C)
 14 of the Social Security Act, the Secretary of Health and
 15 Human Services shall apply the policy directive issued by
 16 the Administrator of the Health Care Financing Adminis-
 17 tration on April 24, 1995, only with respect to items and
 18 services furnished on or after such date.

19 **PART 3—FAILSAFE**

20 **SEC. 15721. FAILSAFE BUDGET MECHANISM.**

21 (a) IN GENERAL.—Title XVIII, as amended by sec-
 22 tions 15106(a) and 15701(a), is amended by adding at
 23 the end the following new section:

24 “FAILSAFE BUDGET MECHANISM

25 “SEC. 1895. (a) REQUIREMENT OF PAYMENT AD-
 26 JUSTMENTS TO ACHIEVE MEDICARE BUDGET TAR-

1 GETS.—If the Secretary determines under subsection
2 (e)(3)(C) before a fiscal year (beginning with fiscal year
3 1998) that—

4 “(1) the fee-for-service expenditures (as defined
5 in subsection (f)) for a sector of medicare services
6 (as defined in subsection (b)) for the fiscal year, will
7 exceed

8 “(2) the allotment specified under subsection
9 (c)(2) for such fiscal year (taking into account any
10 adjustment in the allotment under subsection (h) for
11 that fiscal year),

12 then, notwithstanding any other provision of this title,
13 there shall be an adjustment (consistent with subsection
14 (d)) in applicable payment rates or payments for items
15 and services included in the sector in the fiscal year so
16 that such expenditures for the sector for the year will be
17 reduced by $133\frac{1}{3}$ percent of the amount of such excess.

18 “(b) SECTORS OF MEDICARE SERVICES DE-
19 SCRIBED.—

20 “(1) IN GENERAL.—For purposes of this sec-
21 tion, items and services included under each of the
22 following subparagraphs shall be considered to be a
23 separate ‘sector’ of medicare services:

24 “(A) Inpatient hospital services.

25 “(B) Home health services.

1 “(C) Extended care services (for inpatients
2 of skilled nursing facilities).

3 “(D) Hospice care.

4 “(E) Physicians’ services (including serv-
5 ices and supplies described in section
6 1861(s)(2)(A)) and services of other health care
7 professionals (including certified registered
8 nurse anesthetists, nurse practitioners, physi-
9 cian assistants, and clinical psychologists) for
10 which separate payment is made under this
11 title.

12 “(F) Outpatient hospital services and am-
13 bulatory facility services.

14 “(G) Durable medical equipment and sup-
15 plies, including prosthetic devices and orthotics.

16 “(H) Diagnostic tests (including clinical
17 laboratory services and x-ray services).

18 “(I) Other items and services.

19 “(2) CLASSIFICATION OF ITEMS AND SERV-
20 ICES.—The Secretary shall classify each type of
21 items and services covered and paid for separately
22 under this title into one of the sectors specified in
23 paragraph (1). After publication of such classifica-
24 tion under subsection (e)(1), the Secretary is not au-

1 thorized to make substantive changes in such classi-
2 fication.

3 “(c) ALLOTMENT.—

4 “(1) ALLOTMENTS FOR EACH SECTOR.—For
5 purposes of this section, subject to subsection (h)(1),
6 the allotment for a sector of medicare services for
7 a fiscal year is equal to the product of—

8 “(A) the total allotment for the fiscal year
9 established under paragraph (2), and

10 “(B) the allotment proportion (specified
11 under paragraph (3)) for the sector and fiscal
12 year involved.

13 “(2) TOTAL ALLOTMENT.—

14 “(A) IN GENERAL.—For purposes of this
15 section, the total allotment for a fiscal year is
16 equal to—

17 “(i) the medicare benefit budget for
18 the fiscal year (as specified under subpara-
19 graph (B)), reduced by

20 “(ii) the amount of payments the Sec-
21 retary estimates will be made in the fiscal
22 year under the MedicarePlus program
23 under part C.

24 In making the estimate under clause (ii), the
25 Secretary shall take into account estimated en-

1 rollment and demographic profile of individuals
2 electing MedicarePlus products.

3 “(B) MEDICARE BENEFIT BUDGET.—For
4 purposes of this subsection, subject to subpara-
5 graph (C), the ‘medicare benefit budget’—

6 “(i) for fiscal year 1997 is \$208.0 bil-
7 lion;

8 “(ii) for fiscal year 1998 is \$217.1
9 billion;

10 “(iii) for fiscal year 1999 is \$228.4
11 billion;

12 “(iv) for fiscal year 2000 is \$246.4
13 billion;

14 “(v) for fiscal year 2001 is \$265.5 bil-
15 lion;

16 “(vi) for fiscal year 2002 is \$288.0
17 billion; and

18 “(vii) for a subsequent fiscal year is
19 equal to the medicare benefit budget under
20 this subparagraph for the preceding fiscal
21 year increased by the product of (I) 1.05,
22 and (II) 1 plus the annual percentage in-
23 crease in the average number of medicare
24 beneficiaries from the previous fiscal year
25 to the fiscal year involved.

1 “(3) MEDICARE ALLOTMENT PROPORTION DE-
2 FINED.—

3 “(A) IN GENERAL.—For purposes of this
4 section and with respect to a sector of medicare
5 services for a fiscal year, the term ‘medicare al-
6 lotment proportion’ means the ratio of—

7 “(i) the baseline-projected medicare
8 expenditures (as determined under sub-
9 paragraph (B)) for the sector for the fiscal
10 year, to

11 “(ii) the sum of such baseline expendi-
12 tures for all such sectors for the fiscal
13 year.

14 “(B) BASELINE-PROJECTED MEDICARE
15 EXPENDITURES.—In this paragraph, the ‘base-
16 line, projected medicare expenditures’ for a sec-
17 tor of medicare services—

18 “(i) for fiscal year 1996 is equal to
19 fee-for-service expenditures for such sector
20 during fiscal year 1995, increased by the
21 baseline annual growth rate for such sector
22 of medicare services for fiscal year 1996
23 (as specified in table in subparagraph (C));
24 and

1 “(ii) for a subsequent fiscal year is
2 equal to the baseline-projected medicare
3 expenditures under this subparagraph for
4 the sector for the previous fiscal year in-
5 creased by the baseline annual growth rate
6 for such sector for the fiscal year involved
7 (as specified in such table).

8 “(C) BASELINE ANNUAL GROWTH
9 RATES.—The following table specifies the base-
10 line annual growth rates for each of the sectors
11 for different fiscal years:

“For the following sector—	Baseline annual growth rates for fiscal year—						
	1996	1997	1998	1999	2000	2001	2002 and there- after
(A) Inpatient hospital services	5.7%	5.6%	6.0%	6.1%	5.7%	5.5%	5.2%
(B) Home health services	17.2%	15.1%	11.7%	9.1%	8.4%	8.1%	7.9%
(C) Extended care services	19.7%	12.3%	9.3%	8.7%	8.6%	8.4%	8.0%
(D) Hospice care	32.0%	24.0%	18.0%	15.0%	12.0%	10.0%	9.0%
(E) Physicians’ services	12.4%	9.7%	8.7%	9.0%	9.3%	9.6%	10.1%
(F) Outpatient hospital services	14.7%	13.9%	14.5%	15.0%	14.1%	13.9%	14.0%
(G) Durable medical equipment and supplies	16.1%	15.5%	13.7%	12.4%	13.2%	13.9%	14.5%
(H) Diagnostic tests	13.1%	11.3%	11.0%	11.4%	11.4%	11.5%	11.9%
(I) Other items and services	11.2%	10.2%	10.9%	12.0%	11.6%	11.6%	11.8%

12 “(d) MANNER OF PAYMENT ADJUSTMENT.—

13 “(1) IN GENERAL.—Subject to the succeeding
14 provisions of this subsection, the Secretary shall
15 apply a payment reduction for a sector for a fiscal
16 year in such a manner as to—

17 “(A) make a change in payment rates (to
18 the maximum extent practicable) at the time

1 payment rates are otherwise changed or subject
2 to change for that fiscal year; and

3 “(B) provide for the full appropriate ad-
4 justment so that the fee-for-service expenditures
5 for the sector for the fiscal year will approxi-
6 mate (and not exceed) the allotment for the sec-
7 tor for the fiscal year.

8 “(2) TAKING INTO ACCOUNT VOLUME AND
9 CASH FLOW.—In providing for an adjustment in
10 payments under this subsection for a sector for a
11 fiscal year, the Secretary shall take into account (in
12 a manner consistent with actuarial projections)—

13 “(A) the impact of such an adjustment on
14 the volume or type of services provided in such
15 sector (and other sectors), and

16 “(B) the fact that an adjustment may
17 apply to items and services furnished in a fiscal
18 year (payment for which may occur in a subse-
19 quent fiscal year),

20 in a manner that is consistent with assuring that
21 total fee-for-services expenditures for each sector for
22 the fiscal year will not exceed the allotment under
23 subsection (c)(1) for such sector for such year.

24 “(3) PROPORTIONALITY OF REDUCTIONS WITH-
25 IN A SECTOR.—In making adjustments under this

1 subsection in payment for items and services in-
 2 cluded within a sector of medicare services for a fis-
 3 cal year, the Secretary shall provide for such an ad-
 4 justment that results (to the maximum extent fea-
 5 sible) in the same percentage reductions in aggre-
 6 gate Federal payments under parts A and B for the
 7 different classes of items and services included with-
 8 in the sector for the fiscal year.

9 “(4) APPLICATION TO PAYMENTS MADE BASED
 10 ON PROSPECTIVE PAYMENT RATES DETERMINED ON
 11 A FISCAL YEAR BASIS.—

12 “(A) IN GENERAL.—In applying subsection
 13 (a) with respect to items and services for which
 14 payment is made under part A or B on the
 15 basis of rates that are established on a prospec-
 16 tive basis for (and in advance of) a fiscal year,
 17 the Secretary shall provide for the payment ad-
 18 justment under such subsection through an ap-
 19 propriate reduction in such rates established for
 20 items and services furnished (or, in the case of
 21 payment for operating costs of inpatient hos-
 22 pital services of subsection (d) hospitals and
 23 subsection (d) Puerto Rico hospitals (as defined
 24 in paragraphs (1)(B) and (9)(A) of section

1 1886(d)), discharges occurring) during such
2 year.

3 “(B) DESCRIPTION OF APPLICATION TO
4 SPECIFIC SERVICES.—The payment adjustment
5 described in subparagraph (A) applies for a fis-
6 cal year to at least the following:

7 “(i) UPDATE FACTOR FOR PAYMENT
8 FOR OPERATING COSTS OF INPATIENT
9 HOSPITAL SERVICES OF PPS HOSPITALS.—
10 To the computation of the applicable per-
11 centage increase specified in section
12 1886(d)(3)(B)(i) for discharges occurring
13 in the fiscal year.

14 “(ii) HOME HEALTH SERVICES.—To
15 the extent payment amounts for home
16 health services are based on per visit pay-
17 ment rates under section 1894, to the com-
18 putation of the increase in the national per
19 visit payment rates established for the year
20 under section 1894(b)(2)(B).

21 “(iii) HOSPICE CARE.—To the update
22 of payment rates for hospice care under
23 section 1814(i) for services furnished dur-
24 ing the fiscal year.

1 “(iv) UPDATE FACTOR FOR PAYMENT
2 OF OPERATING COSTS OF INPATIENT HOS-
3 PITAL SERVICES OF PPS-EXEMPT HOS-
4 PITALS.—To the computation of the target
5 amount under section 1886(b)(3) for dis-
6 charges occurring during the fiscal year.

7 “(v) COVERED NON-ROUTINE SERV-
8 ICES OF SKILLED NURSING FACILITIES.—
9 To the computation of the facility per stay
10 limits for the year under section 1888A(d)
11 for covered non-routine services of a skilled
12 nursing facility (as described in such sec-
13 tion).

14 “(5) APPLICATION TO PAYMENTS MADE BASED
15 ON PROSPECTIVE PAYMENT RATES DETERMINED ON
16 A CALENDAR YEAR BASIS.—

17 “(A) IN GENERAL.—In applying subsection
18 (a) for a fiscal year with respect to items and
19 services for which payment is made under part
20 A or B on the basis of rates that are estab-
21 lished on a prospective basis for (and in ad-
22 vance of) a calendar year, the Secretary shall
23 provide for the payment adjustment under such
24 subsection through an appropriate reduction in
25 such rates established for items and services

1 furnished at any time during such calendar
2 year as follows:

3 “(i) For fiscal year 1997, the reduc-
4 tion shall be made for payment rates dur-
5 ing calendar year 1997 in a manner so as
6 to achieve the necessary payment reduc-
7 tions for such fiscal year for items and
8 services furnished during the first 3 quar-
9 ters of calendar year 1997.

10 “(ii) For a subsequent fiscal year, the
11 reduction shall be made for payment rates
12 during the calendar year in which the fis-
13 cal year ends in a manner so as to achieve
14 the necessary payment reductions for such
15 fiscal year for items and services furnished
16 during the first 3 quarters of the calendar
17 year, but also taking into account the pay-
18 ment reductions made in the first quarter
19 of the fiscal year resulting from payment
20 reductions made under this paragraph for
21 the previous calendar year.

22 “(iii) Payment rate reductions ef-
23 fected under this subparagraph for a cal-
24 endar year and applicable to the last 3
25 quarters of the fiscal year in which the cal-

1 endar year ends shall continue to apply
2 during the first quarter of the succeeding
3 fiscal year.

4 “(B) APPLICATION IN SPECIFIC CASES.—

5 The payment adjustment described in subpara-
6 graph (A) applies for a fiscal year to at least
7 the following:

8 “(i) UPDATE IN CONVERSION FACTOR
9 FOR PHYSICIANS’ SERVICES.—To the com-
10 putation of the conversion factor under
11 subsection (d) of section 1848 used in the
12 fee schedule established under subsection
13 (b) of such section, for items and services
14 furnished during the calendar year in
15 which the fiscal year ends.

16 “(ii) PAYMENT RATES FOR OTHER
17 HEALTH CARE PROFESSIONALS.—To the
18 computation of payments for professional
19 services of certified registered nurse anes-
20 thetists under section 1833(l), nurse mid-
21 wives, physician assistants, nurse practi-
22 tioners and clinical nurse specialists under
23 section 1833(r), clinical psychologists, clin-
24 ical social workers, physical or occupational
25 therapists, and any other health profes-

sionals for which payment rates are based
(in whole or in part) on payments for physicians' services, for services furnished during the calendar year in which the fiscal year ends.

“(iii) UPDATE IN LAB FEE SCHEDULE.—To the computation of the fee schedule amount under section 1833(h)(2) for clinical diagnostic laboratory services furnished during the calendar year in which the fiscal year ends.

“(iv) UPDATE IN REASONABLE CHARGES FOR VACCINES.—To the computation of the reasonable charge for vaccines described in section 1861(s)(10) for vaccines furnished during the calendar year in which the fiscal year ends.

“(v) DURABLE MEDICAL EQUIPMENT-RELATED ITEMS.—To the computation of the payment basis under section 1834(a)(1)(B) for covered items described in section 1834(a)(13), for items furnished during the calendar year in which the fiscal year ends.

1 “(vi) RADIOLOGIST SERVICES.—To
2 the computation of conversion factors for
3 radiologist services under section 1834(b),
4 for services furnished during the calendar
5 year in which the fiscal year ends.

6 “(vii) SCREENING MAMMOGRAPHY.—
7 To the computation of payment rates for
8 screening mammography under section
9 1834(c)(1)(C)(ii), for screening mammog-
10 raphy performed during the calendar year
11 in which the fiscal year ends.

12 “(viii) PROSTHETICS AND
13 ORTHOTICS.—To the computation of the
14 amount to be recognized under section
15 1834(h) for payment for prosthetic devices
16 and orthotics and prosthetics, for items
17 furnished during the calendar year in
18 which the fiscal year ends.

19 “(ix) SURGICAL DRESSINGS.—To the
20 computation of the payment amount re-
21 ferred to in section 1834(i)(1)(B) for sur-
22 gical dressings, for items furnished during
23 the calendar year in which the fiscal year
24 ends.

1 “(x) PARENTERAL AND ENTERAL NU-
2 TRITION.—To the computation of reason-
3 able charge screens for payment for paren-
4 teral and enteral nutrition under section
5 1834(h), for nutrients furnished during the
6 calendar year in which the fiscal year ends.

7 “(xi) AMBULANCE SERVICES.—To the
8 computation of limits on reasonable
9 charges for ambulance services, for services
10 furnished during the calendar year in
11 which the fiscal year ends.

12 “(6) APPLICATION TO PAYMENTS MADE BASED
13 ON COSTS DURING A COST REPORTING PERIOD.—

14 “(A) IN GENERAL.—In applying subsection
15 (a) for a fiscal year with respect to items and
16 services for which payment is made under part
17 A or B on the basis of costs incurred for items
18 and services in a cost reporting period, the Sec-
19 retary shall provide for the payment adjustment
20 under such subsection for a fiscal year through
21 an appropriate proportional reduction in the
22 payment for costs for such items and services
23 incurred at any time during each cost reporting
24 period any part of which occurs during the fis-
25 cal year involved, but only (for each such cost

1 reporting period) in the same proportion as the
2 fraction of the cost reporting period that occurs
3 during the fiscal year involved.

4 “(B) APPLICATION IN SPECIFIC CASES.—
5 The payment adjustment described in subpara-
6 graph (A) applies for a fiscal year to at least
7 the following:

8 “(i) CAPITAL-RELATED COSTS OF
9 HOSPITAL SERVICES.—To the computation
10 of payment amounts for inpatient and out-
11 patient hospital services under sections
12 1886(g) and 1861(v) for portions of cost
13 reporting periods occurring during the fis-
14 cal year.

15 “(ii) OPERATING COSTS FOR PPS-EX-
16 EMPT HOSPITALS.—To the computation of
17 payment amounts under section 1886(b)
18 for operating costs of inpatient hospital
19 services of PPS-exempt hospitals for por-
20 tions of cost reporting periods occurring
21 during the fiscal year.

22 “(iii) DIRECT GRADUATE MEDICAL
23 EDUCATION.—To the computation of pay-
24 ment amounts under section 1886(h) for
25 reasonable costs of direct graduate medical

1 education costs for portions of cost report-
2 ing periods occurring during the fiscal
3 year.

4 “(iv) INPATIENT RURAL PRIMARY
5 CARE HOSPITAL SERVICES.—To the com-
6 putation of payment amounts under sec-
7 tion 1814(j) for inpatient rural primary
8 care hospital services for portions of cost
9 reporting periods occurring during the fis-
10 cal year.

11 “(v) EXTENDED CARE SERVICES OF A
12 SKILLED NURSING FACILITY.—To the com-
13 putation of payment amounts under sec-
14 tion 1861(v) for post-hospital extended
15 care services of a skilled nursing facility
16 (other than covered non-routine services
17 subject to section 1888A) for portions of
18 cost reporting periods occurring during the
19 fiscal year.

20 “(vi) REASONABLE COST CON-
21 TRACTS.—To the computation of payment
22 amounts under section 1833(a)(1)(A) for
23 organizations for portions of cost reporting
24 periods occurring during the fiscal year.

1 “(vii) HOME HEALTH SERVICES.—
2 Subject to paragraph (4)(B)(ii), for pay-
3 ment amounts for home health services, for
4 portions of cost reporting periods occurring
5 during such fiscal year.

6 “(7) OTHER.—In applying subsection (a) for a
7 fiscal year with respect to items and services for
8 which payment is made under part A or B on a
9 basis not described in a previous paragraph of this
10 subsection, the Secretary shall provide for the pay-
11 ment adjustment under such subsection through an
12 appropriate proportional reduction in the payments
13 (or payment bases for items and services furnished)
14 during the fiscal year.

15 “(8) ADJUSTMENT OF PAYMENT LIMITS.—The
16 Secretary shall provide for such proportional adjust-
17 ment in any limits on payment established under
18 part A or B for payment for items and services with-
19 in a sector as may be appropriate based on (and in
20 order to properly carry out) the adjustment on the
21 amount of payment under this subsection in the sec-
22 tor.

23 “(9) REFERENCES TO PAYMENT RATES.—Ex-
24 cept as the Secretary may provide, any reference in
25 this title (other than this section) to a payment rate

1 is deemed a reference to such a rate as adjusted
2 under this subsection.

3 “(e) PUBLICATION OF DETERMINATIONS; JUDICIAL
4 REVIEW.—

5 “(1) ONE-TIME PUBLICATION OF SECTORS AND
6 GENERAL PAYMENT ADJUSTMENT METHODOLOGY.—

7 Not later than October 1, 1996, the Secretary shall
8 publish in the Federal Register the classification of
9 medicare items and services into the sectors of medi-
10 care services under subsection (b) and the general
11 methodology to be used in applying payment adjust-
12 ments to the different classes of items and services
13 within the sectors.

14 “(2) INCLUSION OF INFORMATION IN PRESI-
15 DENT’S BUDGET.—

16 “(A) IN GENERAL.—With respect to fiscal
17 years beginning with fiscal year 1999, the
18 President shall include in the budget submitted
19 under section 1105 of title 31, United States
20 Code, information on—

21 “(i) the fee-for-service expenditures,
22 within each sector, for the second previous
23 fiscal year, and how such expenditures
24 compare to the adjusted sector allotment
25 for that sector for that fiscal year; and

1 “(ii) actual annual growth rates for
2 fee-for-service expenditures in the different
3 sectors in the second previous fiscal year.

4 “(B) RECOMMENDATIONS REGARDING
5 GROWTH FACTORS.—The President may include
6 in such budget for a fiscal year (beginning with
7 fiscal year 1998) recommendations regarding
8 percentages that should be applied (for one or
9 more fiscal years beginning with that fiscal
10 year) instead of the baseline annual growth
11 rates under subsection (c)(3)(C). Such rec-
12 ommendations shall take into account medically
13 appropriate practice patterns.

14 “(3) DETERMINATIONS CONCERNING PAYMENT
15 ADJUSTMENTS.—

16 “(A) RECOMMENDATIONS OF COMMIS-
17 SION.—By not later than March 1 of each year
18 (beginning with 1997), the Medicare Payment
19 Review Commission shall submit to the Sec-
20 retary and the Congress a report that analyzes
21 the previous operation (if any) of this section
22 and that includes recommendations concerning
23 the manner in which this section should be ap-
24 plied for the following fiscal year.

1 “(B) PRELIMINARY NOTICE BY SEC-
2 RETARY.—Not later than May 15 preceding the
3 beginning of each fiscal year (beginning with
4 fiscal year 1998), the Secretary shall publish in
5 the Federal Register a notice containing the
6 Secretary’s preliminary determination, for each
7 sector of medicare services, concerning the fol-
8 lowing:

9 “(i) The projected allotment under
10 subsection (c) for such sector for the fiscal
11 year.

12 “(ii) Whether there will be a payment
13 adjustment for items and services included
14 in such sector for the fiscal year under
15 subsection (a).

16 “(iii) If there will be such an adjust-
17 ment, the size of such adjustment and the
18 methodology to be used in making such a
19 payment adjustment for classes of items
20 and services included in such sector.

21 “(iv) Beginning with fiscal year 1999,
22 the fee-for-service expenditures for such
23 sector for the second preceding fiscal year.

24 Such notice shall include an explanation of the
25 basis for such determination. Determinations

1 under this subparagraph and subparagraph (C)
2 shall be based on the best data available at the
3 time of such determinations.

4 “(C) FINAL DETERMINATION.—Not later
5 than September 1 preceding the beginning of
6 each fiscal year (beginning with fiscal year
7 1998), the Secretary shall publish in the Fed-
8 eral Register a final determination, for each
9 sector of medicare services, concerning the mat-
10 ters described in subparagraph (B) and an ex-
11 planation of the reasons for any differences be-
12 tween such determination and the preliminary
13 determination for such fiscal year published
14 under subparagraph (B).

15 “(4) LIMITATION ON ADMINISTRATIVE OR JUDI-
16 CIAL REVIEW.—There shall be no administrative or
17 judicial review under section 1878 or otherwise of—

18 “(A) the classification of items and serv-
19 ices among the sectors of medicare services
20 under subsection (b),

21 “(B) the determination of the amounts of
22 allotments for the different sectors of medicare
23 services under subsection (c),

1 “(C) the determination of the amount (or
2 method of application) of any payment adjust-
3 ment under subsection (d), or

4 “(D) any adjustment in an allotment ef-
5 fected under subsection (h).

6 “(f) FEE-FOR-SERVICE EXPENDITURES DEFINED.—

7 In this section, the term ‘fee-for-service expenditures’, for
8 items and services within a sector of medicare services in
9 a fiscal year, means amounts payable for such items and
10 services which are furnished during the fiscal year, and—

11 “(1) includes types of expenses otherwise reim-
12 bursable under parts A and B (including administra-
13 tive costs incurred by organizations described in sec-
14 tions 1816 and 1842) with respect to such items and
15 services, and

16 “(2) does not include amounts paid under part
17 C.

18 “(g) EXPEDITED PROCESS FOR ADJUSTMENT OF
19 SECTOR GROWTH RATES.—

20 “(1) OPTIONAL INCLUSION OF LEGISLATIVE
21 PROPOSAL.—The President may include in rec-
22 ommendations under subsection (e)(2)(B) submitted
23 with respect to a fiscal year a specific legislative pro-
24 posal that provides only for the substitution of per-
25 centages specified in the proposal for one or more of

1 the baseline annual growth rates (specified in the
2 table in subsection (c)(3)(C) or in a previous legisla-
3 tive proposal under this subsection) for that fiscal
4 year or any subsequent fiscal year.

5 “(2) CONGRESSIONAL CONSIDERATION.—

6 “(A) IN GENERAL.—The percentages con-
7 tained in a legislative proposal submitted under
8 paragraph (1) shall apply under this section if
9 a joint resolution (described in subparagraph
10 (B)) approving such proposal is enacted, in ac-
11 cordance with the provisions of subparagraph
12 (C), before the end of the 60-day period begin-
13 ning on the date on which such proposal was
14 submitted. For purposes of applying the preced-
15 ing sentence and subparagraphs (B) and (C),
16 the days on which either House of Congress is
17 not in session because of an adjournment of
18 more than three days to a day certain shall be
19 excluded in the computation of a period.

20 “(B) JOINT RESOLUTION OF APPROVAL.—

21 A joint resolution described in this subpara-
22 graph means only a joint resolution which is in-
23 troduced within the 10-day period beginning on
24 the date on which the President submits a pro-
25 posal under paragraph (1) and—

1 “(i) which does not have a preamble;

2 “(ii) the matter after the resolving
3 clause of which is as follows: ‘That Con-
4 gress approves the proposal of the Presi-
5 dent providing for substitution of percent-
6 ages for certain baseline annual growth
7 rates under section 1895 of the Social Se-
8 curity Act, as submitted by the President
9 on _____.’, the blank space
10 being filled in with the appropriate date;
11 and

12 “(iii) the title of which is as follows:
13 ‘Joint resolution approving Presidential
14 proposal to substitute certain specified per-
15 centages for baseline annual growth rates
16 under section 1895 of the Social Security
17 Act, as submitted by the President on
18 _____.’, the blank space being
19 filled in with the appropriate date.

20 “(C) PROCEDURES FOR CONSIDERATION
21 OF RESOLUTION OF APPROVAL.—Subject to
22 subparagraph (D), the provisions of section
23 2908 (other than subsection (a)) of the Defense
24 Base Closure and Realignment Act of 1990
25 shall apply to the consideration of a joint reso-

lution described in subparagraph (B) in the same manner as such provisions apply to a joint resolution described in section 2908(a) of such Act.

“(D) SPECIAL RULES.—For purposes of applying subparagraph (C) with respect to such provisions—

“(i) any reference to the Committee on Armed Services of the House of Representatives shall be deemed a reference to an appropriate Committee of the House of Representatives (specified by the Speaker of the House of Representatives at the time of submission of a legislative proposal under paragraph (1)) and any reference to the Committee on Armed Services of the Senate shall be deemed a reference to the Committee on Finance of the Senate;

“(ii) any reference to a resolution of which a committee shall be discharged from further consideration shall be deemed to be a reference to the first such resolution introduced; and

“(iii) any reference to the date on which the President transmits a report

1 shall be deemed a reference to the date on
2 which the President submits the legislative
3 proposal under paragraph (1).

4 “(h) LOOK-BACK ADJUSTMENT IN ALLOTMENTS TO
5 REFLECT ACTUAL EXPENDITURES.—

6 “(1) IN GENERAL.—If the Secretary determines
7 under subsection (e)(3)(B) with respect to a particu-
8 lar fiscal year (beginning with fiscal year 1999) that
9 the fee-for-service expenditures for a sector of medi-
10 care services for the second preceding fiscal year—

11 “(A) exceeded the adjusted allotment for
12 such sector for such year (as defined in para-
13 graph (2)), then the allotment for the sector for
14 the particular fiscal year shall be reduced by
15 133 $\frac{1}{3}$ percent of the amount of such excess, or

16 “(B) was less than the adjusted allotment
17 for such sector for such year, then the allot-
18 ment for the sector for the particular fiscal year
19 shall be increased by the amount of such defi-
20 cit.

21 “(2) ADJUSTED ALLOTMENT.—The adjusted al-
22 lotment under this paragraph for a sector for a fis-
23 cal year is—

24 “(A) the amount that would be computed
25 as the allotment under subsection (c) for the

1 sector for the fiscal year if the actual amount
 2 of payments made in the fiscal year under the
 3 MedicarePlus program under part C in the fis-
 4 cal year were substituted for the amount de-
 5 scribed in subsection (c)(2)(A)(ii) for that fiscal
 6 year,

7 “(B) adjusted to take into account the
 8 amount of any adjustment under paragraph (1)
 9 for that fiscal year (based on expenditures in
 10 the second previous fiscal year).

11 “(i) PROSPECTIVE APPLICATION OF CERTAIN NA-
 12 TIONAL COVERAGE DETERMINATIONS.—In the case of a
 13 national coverage determination that the Secretary
 14 projects will result in significant additional expenditures
 15 under this title (taking into account any substitution for
 16 existing procedures or technologies), such determination
 17 shall not become effective before the beginning of the fiscal
 18 year that begins after the date of such determination and
 19 shall apply to contracts under part C entered into (or re-
 20 newed) after the date of such determination.”.

21 (b) REPORT OF TRUSTEES ON GROWTH RATE IN
 22 PART A EXPENDITURES.—Section 1817 (42 U.S.C.
 23 1395i) is amended by adding at the end the following new
 24 subsection:

1 “(k) Each annual report provided in subsection (b)(2)
2 shall include information regarding the annual rate of
3 growth in program expenditures that would be required
4 to maintain the financial solvency of the Trust Fund and
5 the extent to which the provisions of section 1895 restrain
6 the rate of growth of expenditures under this part in order
7 to achieve such solvency.”.

8 **PART 4—ADMINISTRATIVE SIMPLIFICATION**

9 **SEC. 15731. STANDARDS FOR MEDICARE INFORMATION**

10 **TRANSACTIONS AND DATA ELEMENTS.**

11 Title XVIII, as amended by section 15031, is amend-
12 ed by inserting after section 1806 the following new sec-
13 tion:

14 “STANDARDS FOR MEDICARE INFORMATION

15 TRANSACTIONS AND DATA ELEMENTS

16 “SEC. 1807. (a) ADOPTION OF STANDARDS FOR
17 DATA ELEMENTS.—

18 “(1) IN GENERAL.—Pursuant to subsection (b),
19 the Secretary shall adopt standards for information
20 transactions and data elements of medicare informa-
21 tion and modifications to the standards under this
22 section that are—

23 “(A) consistent with the objective of reduc-
24 ing the administrative costs of providing and
25 paying for health care; and

1 “(B) developed or modified by a standard
2 setting organization (as defined in subsection
3 (h)(8)).

4 “(2) SPECIAL RULE RELATING TO DATA ELE-
5 MENTS.—The Secretary may adopt or modify a
6 standard relating to data elements that is different
7 from the standard developed by a standard setting
8 organization, if—

9 “(A) the different standard or modification
10 will substantially reduce administrative costs to
11 health care providers and health plans com-
12 pared to the alternative; and

13 “(B) the standard or modification is pro-
14 mulgated in accordance with the rulemaking
15 procedures of subchapter III of chapter 5 of
16 title 5, United States Code.

17 “(3) SECURITY STANDARDS FOR HEALTH IN-
18 FORMATION NETWORK.—

19 “(A) IN GENERAL.—Each person, who
20 maintains or transmits medicare information or
21 data elements of medicare information and is
22 subject to this section, shall maintain reason-
23 able and appropriate administrative, technical,
24 and physical safeguards—

1 “(i) to ensure the integrity and con-
2 fidentiality of the information;

3 “(ii) to protect against any reasonably
4 anticipated—

5 “(I) threats or hazards to the se-
6 curity or integrity of the information;
7 and

8 “(II) unauthorized uses or disclo-
9 sures of the information; and

10 “(iii) to otherwise ensure compliance
11 with this section by the officers and em-
12 ployees of such person.

13 “(B) SECURITY STANDARDS.—The Sec-
14 retary shall establish security standards and
15 modifications to such standards with respect to
16 medicare information network services, health
17 plans, and health care providers that—

18 “(i) take into account—

19 “(I) the technical capabilities of
20 record systems used to maintain medi-
21 care information;

22 “(II) the costs of security meas-
23 ures;

1 “(III) the need for training per-
 2 sons who have access to medicare in-
 3 formation; and

4 “(IV) the value of audit trails in
 5 computerized record systems; and

6 “(ii) ensure that a medicare informa-
 7 tion network service, if it is part of a larg-
 8 er organization, has policies and security
 9 procedures which isolate the activities of
 10 such service with respect to processing in-
 11 formation in a manner that prevents unau-
 12 thorized access to such information by
 13 such larger organization.

14 The security standards established by the Sec-
 15 retary shall be based on the standards devel-
 16 oped or modified by standard setting organiza-
 17 tions. If such standards do not exist, the Sec-
 18 retary shall rely on the recommendations of the
 19 Medicare Information Advisory Committee (es-
 20 tablished under subsection (g)) and shall con-
 21 sult with appropriate government agencies and
 22 private organizations in accordance with para-
 23 graph (5).

24 “(4) IMPLEMENTATION SPECIFICATIONS.—The
 25 Secretary shall establish specifications for imple-

1 menting each of the standards and the modifications
2 to the standards adopted pursuant to paragraph (1)
3 or (3).

4 “(5) ASSISTANCE TO THE SECRETARY.—In
5 complying with the requirements of this section, the
6 Secretary shall rely on recommendations of the Med-
7 icare Information Advisory Committee established
8 under subsection (g) and shall consult with appro-
9 priate Federal and State agencies and private orga-
10 nizations. The Secretary shall publish in the Federal
11 Register the recommendations of the Medicare Infor-
12 mation Advisory Committee regarding the adoption
13 of a standard under this section.

14 “(b) STANDARDS FOR INFORMATION TRANSACTIONS
15 AND DATA ELEMENTS.—

16 “(1) IN GENERAL.—The Secretary shall adopt
17 standards for transactions and data elements to
18 make medicare information uniformly available to be
19 exchanged electronically, that is—

20 “(A) appropriate for the following financial
21 and administrative transactions: claims (includ-
22 ing coordination of benefits) or equivalent en-
23 counter information, enrollment and
24 disenrollment, eligibility, premium payments,
25 and referral certification and authorization; and

1 “(B) related to other financial and admin-
2 istrative transactions determined appropriate by
3 the Secretary consistent with the goals of im-
4 proving the operation of the health care system
5 and reducing administrative costs.

6 “(2) UNIQUE HEALTH IDENTIFIERS.—

7 “(A) ADOPTION OF STANDARDS.—The
8 Secretary shall adopt standards providing for a
9 standard unique health identifier for each indi-
10 vidual, employer, health plan, and health care
11 provider for use in the medicare information
12 system. In developing unique health identifiers
13 for each health plan and health care provider,
14 the Secretary shall take into account multiple
15 uses for identifiers and multiple locations and
16 specialty classifications for health care provid-
17 ers.

18 “(B) PENALTY FOR IMPROPER DISCLO-
19 SURE.—A person who knowingly uses or causes
20 to be used a unique health identifier under sub-
21 paragraph (A) for a purpose that is not author-
22 ized by the Secretary shall—

23 “(i) be fined not more than \$50,000,
24 imprisoned not more than 1 year, or both;
25 or

1 “(ii) if the offense is committed under
2 false pretenses, be fined not more than
3 \$100,000, imprisoned not more than 5
4 years, or both.

5 “(3) CODE SETS.—

6 “(A) IN GENERAL.—The Secretary, in con-
7 sultation with the Medicare Information Advi-
8 sory Committee, experts from the private sec-
9 tor, and Federal and State agencies, shall—

10 “(i) select code sets for appropriate
11 data elements from among the code sets
12 that have been developed by private and
13 public entities; or

14 “(ii) establish code sets for such data
15 elements if no code sets for the data ele-
16 ments have been developed.

17 “(B) DISTRIBUTION.—The Secretary shall
18 establish efficient and low-cost procedures for
19 distribution (including electronic distribution) of
20 code sets and modifications made to such code
21 sets under subsection (c)(2).

22 “(4) ELECTRONIC SIGNATURE.—

23 “(A) IN GENERAL.—The Secretary, after
24 consultation with the Medicare Information Ad-
25 visory Committee, shall promulgate regulations

1 specifying procedures for the electronic trans-
 2 mission and authentication of signatures, com-
 3 pliance with which will be deemed to satisfy
 4 Federal and State statutory requirements for
 5 written signatures with respect to information
 6 transactions required by this section and writ-
 7 ten signatures on enrollment and disenrollment
 8 forms.

9 “(B) PAYMENTS FOR SERVICES AND PRE-
 10 MIUMS.—Nothing in this section shall be con-
 11 strued to prohibit the payment of health care
 12 services or health plan premiums by debit, cred-
 13 it, payment card or numbers, or other electronic
 14 means.

15 “(5) TRANSFER OF INFORMATION BETWEEN
 16 HEALTH PLANS.—The Secretary shall develop rules
 17 and procedures—

18 “(A) for determining the financial liability
 19 of health plans when health care benefits are
 20 payable under two or more health plans; and

21 “(B) for transferring among health plans
 22 appropriate standard data elements needed for
 23 the coordination of benefits, the sequential
 24 processing of claims, and other data elements

1 for individuals who have more than one health
2 plan.

3 “(6) COORDINATION OF BENEFITS.—If, at the
4 end of the 5-year period beginning on the date of the
5 enactment of this section, the Secretary determines
6 that additional transaction standards for coordinat-
7 ing benefits are necessary to reduce administrative
8 costs or duplicative (or inappropriate) payment of
9 claims, the Secretary shall establish further trans-
10 action standards for the coordination of benefits be-
11 tween health plans.

12 “(7) PROTECTION OF TRADE SECRETS.—Ex-
13 cept as otherwise required by law, the standards
14 adopted under this section shall not require disclo-
15 sure of trade secrets or confidential commercial in-
16 formation by an entity operating a medicare infor-
17 mation network.

18 “(c) TIMETABLES FOR ADOPTION OF STANDARDS.—

19 “(1) INITIAL STANDARDS.—Not later than 18
20 months after the date of the enactment of this sec-
21 tion, the Secretary shall adopt standards relating to
22 the information transactions, data elements of medi-
23 care information and security described in sub-
24 sections (a) and (b).

1 “(2) ADDITIONS AND MODIFICATIONS TO
2 STANDARDS.—

3 “(A) IN GENERAL.—The Secretary shall
4 review the standards adopted under this section
5 and shall adopt additional or modified stand-
6 ards, that have been developed or modified by
7 a standard setting organization, as determined
8 appropriate, but not more frequently than once
9 every 12 months. Any addition or modification
10 to such standards shall be completed in a man-
11 ner which minimizes the disruption and cost of
12 compliance.

13 “(B) ADDITIONS AND MODIFICATIONS TO
14 CODE SETS.—

15 “(i) IN GENERAL.—The Secretary
16 shall ensure that procedures exist for the
17 routine maintenance, testing, enhancement,
18 and expansion of code sets.

19 “(ii) ADDITIONAL RULES.—If a code
20 set is modified under this paragraph, the
21 modified code set shall include instructions
22 on how data elements of medicare informa-
23 tion that were encoded prior to the modi-
24 fication may be converted or translated so
25 as to preserve the informational value of

1 the data elements that existed before the
 2 modification. Any modification to a code
 3 set under this paragraph shall be imple-
 4 mented in a manner that minimizes the
 5 disruption and cost of complying with such
 6 modification.

7 “(d) REQUIREMENTS FOR HEALTH PLANS.—

8 “(1) IN GENERAL.—If a person desires to con-
 9 duct any of the information transactions described
 10 in subsection (b)(1) with a health plan as a standard
 11 transaction, the health plan shall conduct such
 12 standard transaction in a timely manner and the in-
 13 formation transmitted or received in connection with
 14 such transaction shall be in the form of standard
 15 data elements of medicare information.

16 “(2) SATISFACTION OF REQUIREMENTS.—A
 17 health plan may satisfy the requirement imposed on
 18 such plan under paragraph (1) by directly transmit-
 19 ting standard data elements of medicare information
 20 or submitting nonstandard data elements to a medi-
 21 care information network service for processing into
 22 standard data elements and transmission.

23 “(3) TIMETABLES FOR COMPLIANCE WITH RE-
 24 QUIREMENTS.—Not later than 24 months after the
 25 date on which standards are adopted under sub-

1 sections (a) and (b) with respect to any type of in-
 2 formation transaction or data element of medicare
 3 information or with respect to security, a health plan
 4 shall comply with the requirements of this section
 5 with respect to such transaction or data element.

6 “(4) COMPLIANCE WITH MODIFIED STAND-
 7 ARDS.—If the Secretary adopts a modified standard
 8 under subsection (a) or (b), a health plan shall be
 9 required to comply with the modified standard at
 10 such time as the Secretary determines appropriate
 11 taking into account the time needed to comply due
 12 to the nature and extent of the modification. How-
 13 ever, the time determined appropriate under the pre-
 14 ceding sentence shall be not earlier than the last day
 15 of the 180-day period beginning on the date such
 16 modified standard is adopted. The Secretary may ex-
 17 tend the time for compliance for small health plans,
 18 if the Secretary determines such extension is appro-
 19 priate.

20 “(e) GENERAL PENALTY FOR FAILURE TO COMPLY
 21 WITH REQUIREMENTS AND STANDARDS.—

22 “(1) GENERAL PENALTY.—

23 “(A) IN GENERAL.—Except as provided in
 24 paragraph (2), the Secretary shall impose on

1 any person that violates a requirement or
2 standard—

3 “(i) with respect to medicare informa-
4 tion transactions, data elements of medi-
5 care information, or security imposed
6 under subsection (a) or (b); or

7 “(ii) with respect to health plans im-
8 posed under subsection (d);

9 a penalty of not more than \$100 for each such
10 violation of a specific standard or requirement,
11 but the total amount imposed for all such viola-
12 tions of a specific standard or requirement dur-
13 ing the calendar year shall not exceed \$25,000.

14 “(B) PROCEDURES.—The provisions of
15 section 1128A (other than subsections (a) and
16 (b) and the second sentence of subsection (f))
17 shall apply to the imposition of a civil money
18 penalty under this paragraph in the same man-
19 ner as such provisions apply to the imposition
20 of a penalty under such section 1128A.

21 “(C) DENIAL OF PAYMENT.—Except as
22 provided in paragraph (2), the Secretary may
23 deny payment under this title for an item or
24 service furnished by a person if the person fails
25 to comply with an applicable requirement or

1 standard for medicare information relating to
2 that item or service.

3 “(2) LIMITATIONS.—

4 “(A) NONCOMPLIANCE NOT DISCOV-
5 ERED.—A penalty may not be imposed under
6 paragraph (1) if it is established to the satisfac-
7 tion of the Secretary that the person liable for
8 the penalty did not know, and by exercising rea-
9 sonable diligence would not have known, that
10 such person failed to comply with the require-
11 ment or standard described in paragraph (1).

12 “(B) FAILURES DUE TO REASONABLE
13 CAUSE.—

14 “(i) IN GENERAL.—Except as pro-
15 vided in clause (ii), a penalty may not be
16 imposed under paragraph (1) if—

17 “(I) the failure to comply was
18 due to reasonable cause and not to
19 willful neglect; and

20 “(II) the failure to comply is cor-
21 rected during the 30-day period begin-
22 ning on the first date the person liable
23 for the penalty knew, or by exercising
24 reasonable diligence would have

1 known, that the failure to comply oc-
2 curred.

3 “(ii) EXTENSION OF PERIOD.—

4 “(I) NO PENALTY.—The period
5 referred to in clause (i)(II) may be ex-
6 tended as determined appropriate by
7 the Secretary based on the nature and
8 extent of the failure to comply.

9 “(II) ASSISTANCE.—If the Sec-
10 retary determines that a health plan
11 failed to comply because such plan
12 was unable to comply, the Secretary
13 may provide technical assistance to
14 such plan during the period described
15 in clause (i)(II). Such assistance shall
16 be provided in any manner determined
17 appropriate by the Secretary.

18 “(C) REDUCTION.—In the case of a failure
19 to comply which is due to reasonable cause and
20 not to willful neglect, any penalty under para-
21 graph (1) that is not entirely waived under sub-
22 paragraph (B) may be waived to the extent that
23 the payment of such penalty would be excessive
24 relative to the compliance failure involved.

25 “(f) EFFECT ON STATE LAW.—

1 “(1) GENERAL EFFECT.—

2 “(A) GENERAL RULE.—Except as provided
3 in subparagraph (B), a provision, requirement,
4 or standard under this section shall supersede
5 any contrary provision of State law, including a
6 provision of State law that requires medical or
7 health plan records (including billing informa-
8 tion) to be maintained or transmitted in written
9 rather than electronic form.

10 “(B) EXCEPTIONS.—A provision, require-
11 ment, or standard under this section shall not
12 supersede a contrary provision of State law if
13 the Secretary determines that the provision of
14 State law should be continued for any reason,
15 including for reasons relating to prevention of
16 fraud and abuse or regulation of controlled sub-
17 stances.

18 “(2) PUBLIC HEALTH REPORTING.—Nothing in
19 this section shall be construed to invalidate or limit
20 the authority, power, or procedures established
21 under any law providing for the reporting of disease
22 or injury, child abuse, birth, or death, public health
23 surveillance, or public health investigation or inter-
24 vention.

1 “(g) MEDICARE INFORMATION ADVISORY COMMIT-
2 TEE.—

3 “(1) ESTABLISHMENT.—There is established a
4 committee to be known as the Medicare Information
5 Advisory Committee (in this subsection referred to
6 as the ‘committee’).

7 “(2) DUTIES.—The committee shall—

8 “(A) advise the Secretary in the develop-
9 ment of standards under this section; and

10 “(B) be generally responsible for advising
11 the Secretary and the Congress on the status
12 and the future of the medicare information net-
13 work.

14 “(3) MEMBERSHIP.—

15 “(A) IN GENERAL.—The committee shall
16 consist of 9 members of whom—

17 “(i) 3 shall be appointed by the Presi-
18 dent;

19 “(ii) 3 shall be appointed by the
20 Speaker of the House of Representatives
21 after consultation with the minority leader
22 of the House of Representatives; and

23 “(iii) 3 shall be appointed by the
24 President pro tempore of the Senate after

1 consultation with the minority leader of
2 the Senate.

3 The appointments of the members shall be
4 made not later than 60 days after the date of
5 the enactment of this section. The President
6 shall designate 1 member as the Chair.

7 “(B) EXPERTISE.—The membership of the
8 committee shall consist of individuals who are
9 of recognized standing and distinction in the
10 areas of information systems, information
11 networking and integration, consumer health,
12 or health care financial management, and who
13 possess the demonstrated capacity to discharge
14 the duties imposed on the committee.

15 “(C) TERMS.—Each member of the com-
16 mittee shall be appointed for a term of 5 years,
17 except that the members first appointed shall
18 serve staggered terms such that the terms of
19 not more than 3 members expire at one time.

20 “(D) INITIAL MEETING.—Not later than
21 30 days after the date on which a majority of
22 the members have been appointed, the commit-
23 tee shall hold its first meeting.

24 “(4) REPORTS.—Not later than 1 year after the
25 date of the enactment of this section, and annually

1 thereafter, the committee shall submit to Congress
2 and the Secretary a report regarding—

3 “(A) the extent to which entities using the
4 medicare information network are meeting the
5 standards adopted under this section and work-
6 ing together to form an integrated network that
7 meets the needs of its users;

8 “(B) the extent to which such entities are
9 meeting the security standards established pur-
10 suant to this section and the types of penalties
11 assessed for noncompliance with such stand-
12 ards;

13 “(C) any problems that exist with respect
14 to implementation of the medicare information
15 network; and

16 “(D) the extent to which timetables under
17 this section are being met.

18 Reports made under this subsection shall be made
19 available to health care providers, health plans, and
20 other entities that use the medicare information net-
21 work to exchange medicare information.

22 “(h) DEFINITIONS.—For purposes of this section:

23 “(1) CODE SET.—The term ‘code set’ means
24 any set of codes used for encoding data elements,

1 such as tables of terms, enrollment information, and
2 encounter data.

3 “(2) COORDINATION OF BENEFITS.—The term
4 ‘coordination of benefits’ means determining and co-
5 ordinating the financial obligations of health plans
6 when health care benefits are payable under such a
7 plan and under this title (including under a
8 MedicarePlus product).

9 “(3) MEDICARE INFORMATION.—The term
10 ‘medicare information’ means any information that
11 relates to the enrollment of individuals under this
12 title (including information relating to elections of
13 MedicarePlus products under section 1805) and the
14 provision of health benefits (including benefits pro-
15 vided under such products) under this title.

16 “(4) MEDICARE INFORMATION NETWORK.—The
17 term ‘medicare information network’ means the
18 medicare information system that is formed through
19 the application of the requirements and standards
20 established under this section.

21 “(5) MEDICARE INFORMATION NETWORK SERV-
22 ICE.—The term ‘medicare information network serv-
23 ice’ means a public or private entity that—

1 “(A) processes or facilitates the processing
2 of nonstandard data elements of medicare infor-
3 mation into standard data elements;

4 “(B) provides the means by which persons
5 may meet the requirements of this section; or

6 “(C) provides specific information process-
7 ing services.

8 “(6) HEALTH PLAN.—The term ‘health plan’
9 means a plan which provides, or pays the cost of,
10 health benefits. Such term includes the following, or
11 any combination thereof:

12 “(A) Part A or part B of this title, and in-
13 cludes a MedicarePlus product.

14 “(B) The medicaid program under title
15 XIX and the MediGrant program under title
16 XXI.

17 “(C) A medicare supplemental policy (as
18 defined in section 1882(g)(1)).

19 “(D) Worker’s compensation or similar in-
20 surance.

21 “(E) Automobile or automobile medical-
22 payment insurance.

23 “(F) A long-term care policy, other than a
24 fixed indemnity policy.

1 “(G) The Federal Employees Health Bene-
2 fit Plan under chapter 89 of title 5, United
3 States Code.

4 “(H) An employee welfare benefit plan, as
5 defined in section 3(1) of the Employee Retirement
6 Income Security Act of 1974 (29 U.S.C.
7 1002(1)), but only to the extent the plan is es-
8 tablished or maintained for the purpose of pro-
9 viding health benefits.

10 “(7) INDIVIDUALLY IDENTIFIABLE MEDICARE
11 INFORMATION.—The term ‘individually identifiable
12 medicare information’ means medicare enrollment
13 information, including demographic information col-
14 lected from an individual, that—

15 “(A) is created or received by a health care
16 provider, health plan, employer, or medicare in-
17 formation network service, and

18 “(B) identifies an individual.

19 “(8) STANDARD SETTING ORGANIZATION.—The
20 term ‘standard setting organization’ means a stand-
21 ard setting organization accredited by the American
22 National Standards Institute.

23 “(9) STANDARD TRANSACTION.—The term
24 ‘standard transaction’ means, when referring to an
25 information transaction or to data elements of medi-

1 care information, any transaction that meets the re-
2 quirements and implementation specifications adopt-
3 ed by the Secretary under subsections (a) and (b).”.

4 **PART 5—OTHER PROVISIONS RELATING TO**
5 **PARTS A AND B**

6 **SEC. 15741. CLARIFICATION OF MEDICARE COVERAGE OF**
7 **ITEMS AND SERVICES ASSOCIATED WITH**
8 **CERTAIN MEDICAL DEVICES APPROVED FOR**
9 **INVESTIGATIONAL USE.**

10 (a) COVERAGE.—Nothing in title XVIII of the Social
11 Security Act may be construed to prohibit coverage under
12 part A or part B of the medicare program of items and
13 services associated with the use of a medical device in the
14 furnishing of inpatient hospital services (as defined for
15 purposes of part A of the medicare program) solely on the
16 grounds that the device is not an approved device, if—

- 17 (1) the device is an investigational device; and
18 (2) the device is used instead of an approved
19 device.

20 (b) CLARIFICATION OF PAYMENT AMOUNT.—Not-
21 withstanding any other provision of title XVIII of the So-
22 cial Security Act, the amount of payment made under the
23 medicare program for any item or service associated with
24 the use of an investigational device in the furnishing of
25 inpatient hospital services (as defined for purposes of part

1 A of the medicare program) may not exceed the amount
2 of the payment which would have been made under the
3 program for the item or service if the item or service were
4 associated with the use of an approved device.

5 (c) DEFINITIONS.—In this section—

6 (1) the term “approved device” means a medi-
7 cal device which has been approved for marketing
8 under pre-market approval under the Federal Food,
9 Drug, and Cosmetic Act or cleared for marketing
10 under a 510(k) notice under such Act; and

11 (2) the term “investigational device” means a
12 medical device (other than a device described in
13 paragraph (1)) which is approved for investigational
14 use under section 520(g) of the Federal Food, Drug,
15 and Cosmetic Act.

16 **SEC. 15742. ADDITIONAL EXCLUSION FROM COVERAGE.**

17 (a) IN GENERAL.—Section 1862(a) (42 U.S.C.
18 1395y(a)), as amended by section 15525(a)(2), section
19 15609B(a), and section 15701(c)(2)(C), is amended—

20 (1) by striking “or” at the end of paragraph
21 (17),

22 (2) by striking the period at the end of para-
23 graph (18) and inserting “; or”, and

24 (3) by inserting after paragraph (18) the fol-
25 lowing new paragraph:

1 “(19) where such expenses are for items or
2 services, or to assist in the purchase, in whole or in
3 part, of health benefit coverage that includes items
4 or services, for the purpose of causing, or assisting
5 in causing, the death, suicide, euthanasia, or mercy
6 killing of a person.”.

7 (b) EFFECTIVE DATE.—The amendments made by
8 subsection (a) shall apply to payment for items and serv-
9 ices furnished on or after the date of the enactment of
10 this Act.

11 **SEC. 15743. COMPETITIVE BIDDING FOR CERTAIN ITEMS**
12 **AND SERVICES.**

13 (a) ESTABLISHMENT OF DEMONSTRATION.—Not
14 later than 1 year after the date of the enactment of this
15 Act, the Secretary of Health and Human Services shall
16 establish and operate over a 2-year period a demonstration
17 project in 2 geographic regions selected by the Secretary
18 under which (notwithstanding any provision of title XVIII
19 of the Social Security Act to the contrary) the amount
20 of payment made under the medicare program for a se-
21 lected item or service (other than clinical diagnostic lab-
22 oratory tests) furnished in the region shall be equal to the
23 price determined pursuant to a competitive bidding proc-
24 ess which meets the requirements of subsection (b).

1 (b) REQUIREMENTS FOR COMPETITIVE BIDDING
 2 PROCESS.—The competitive bidding process used under
 3 the demonstration project under this section shall meet
 4 such requirements as the Secretary may impose to ensure
 5 the cost-effective delivery to medicare beneficiaries in the
 6 project region of items and services of high quality.

7 (c) DETERMINATION OF SELECTED ITEMS OR SERV-
 8 ICES.—The Secretary shall select items and services to be
 9 subject to the demonstration project under this section if
 10 the Secretary determines that the use of competitive bid-
 11 ding with respect to the item or service under the project
 12 will be appropriate and cost-effective. In determining the
 13 items or services to be selected, the Secretary shall consult
 14 with an advisory taskforce which includes representatives
 15 of providers and suppliers of items and services (including
 16 small business providers and suppliers) in each geographic
 17 region in which the project will be effective.

18 **SEC. 15744. DISCLOSURE OF CRIMINAL CONVICTIONS RE-**
 19 **LATING TO PROVISION OF HOME HEALTH**
 20 **SERVICES.**

21 (a) IN GENERAL.—Section 1891 (42 U.S.C.
 22 1395bbb) is amended by adding at the end the following
 23 new subsection:

24 “(g) The Secretary, and each State or local survey
 25 agency or other State agency responsible for monitoring

1 compliance of home health agencies with requirements,
2 shall make available, upon request of any person, informa-
3 tion the Secretary or agency has on individuals who have
4 been convicted of felonies relating to the provision of home
5 health services.”.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall take effect on the date of the enact-
8 ment of this Act.

9 **SEC. 15745. REQUIRING RENAL DIALYSIS FACILITIES TO**
10 **MAKE SERVICES AVAILABLE ON A 24-HOUR**
11 **BASIS.**

12 (a) IN GENERAL.—Section 1881(b)(1) (42 U.S.C.
13 1395rr(b)(1)) is amended by striking the period at the end
14 and inserting the following: “, together with a requirement
15 (in the case of a renal dialysis facility) that the facility
16 make institutional dialysis services and supplies available
17 on a 24-hour basis (either directly or through arrange-
18 ments with providers of services or other renal dialysis fa-
19 cilities that meet the requirements of such subparagraph)
20 and that the facility provide notice informing its patients
21 of the other providers of services or renal dialysis facilities
22 (if any) with whom the facility has made such arrange-
23 ments.”.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to items and services furnished
3 on or after January 1, 1996.

4 **Subtitle I—Clinical Laboratories**

5 **SEC. 15801. EXEMPTION OF PHYSICIAN OFFICE LABORA-** 6 **TORIES.**

7 Section 353(d) of the Public Health Service Act (42
8 U.S.C. 263a(d)) is amended—

9 (1) by redesignating paragraphs (2), (3), and
10 (4) as paragraphs (3), (4), and (5) and by adding
11 after paragraph (1) the following:

12 “(2) EXEMPTION OF PHYSICIAN OFFICE LAB-
13 ORATORIES.—

14 “(A) IN GENERAL.—Except as provided in
15 subparagraph (B), a clinical laboratory in a
16 physician’s office (including an office of a group
17 of physicians) which is directed by a physician
18 and in which examinations and procedures are
19 either performed by a physician or by individ-
20 uals supervised by a physician solely as an ad-
21 junct to other services provided by the physi-
22 cian’s office is exempt from this section.

23 “(B) EXCEPTION.—A clinical laboratory
24 described in subparagraph (A) is not exempt

1 from this section when it performs a pap smear
2 (Papanicolaou Smear) analysis.

3 “(C) DEFINITION.—For purposes of sub-
4 paragraph (A), the term ‘physician’ has the
5 same meaning as is prescribed for such term by
6 section 1861(r) of the Social Security Act (42
7 U.S.C. 1395x(r)).”;

8 (2) in paragraph (3) (as so redesignated) by
9 striking “(3)” and inserting “(4)”; and

10 (3) in paragraphs (4) and (5) (as so redesign-
11 ated) by striking “(2)” and inserting “(3)”.

12 **Subtitle J—Lock-Box Provisions**
13 **for Medicare Part B Savings**
14 **from Growth Reductions**

15 **SEC. 15901. ESTABLISHMENT OF MEDICARE GROWTH RE-**
16 **DUCTION TRUST FUND FOR PART B SAVINGS.**

17 Part B of title XVIII is amended by inserting after
18 section 1841 the following new section:

19 “MEDICARE GROWTH REDUCTION TRUST FUND

20 “SEC. 1841A. (a)(1) There is hereby created on the
21 books of the Treasury of the United States a trust fund
22 to be known as the ‘Federal Medicare Growth Reduction
23 Trust Fund’ (in this section referred to as the ‘Trust
24 Fund’). The Trust Fund shall consist of such gifts and
25 bequests as may be made as provided in section 201(i)(1)
26 and amounts appropriated under paragraph (2).

1 “(2) There are hereby appropriated to the Trust
2 Fund, out of any amounts in the Treasury not otherwise
3 appropriated, amounts equivalent to 100 percent of the
4 Secretary’s estimate of the reductions in outlays under
5 this part that are attributable to the Medicare Preserva-
6 tion Act of 1995. The amounts appropriated by the pre-
7 ceding sentence shall be transferred from time to time (not
8 less frequently than monthly) from the general fund in the
9 Treasury to the Trust Fund.

10 “(3)(A) Subject to subparagraph (B), with respect to
11 monies transferred to the Trust Fund, no transfers, au-
12 thorizations of appropriations, or appropriations are per-
13 mitted.

14 “(B) Beginning with fiscal year 2003, the Secretary
15 may expend funds in the Trust Fund to carry out this
16 title, but only to the extent provided by Congress in ad-
17 vance through a specific amendment to this section.

18 “(b) The provisions of subsections (b) through (e) of
19 section 1841 shall apply to the Trust Fund in the same
20 manner as they apply to the Federal Supplementary Medi-
21 cal Insurance Trust Fund, except that the Board of Trust-
22 ees and Managing Trustee of the Trust Fund shall be
23 composed of the members of the Board of Trustees and

1 the Managing Trustee, respectively, of the Federal Supple-
 2 mentary Medical Insurance Trust Fund.”.

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